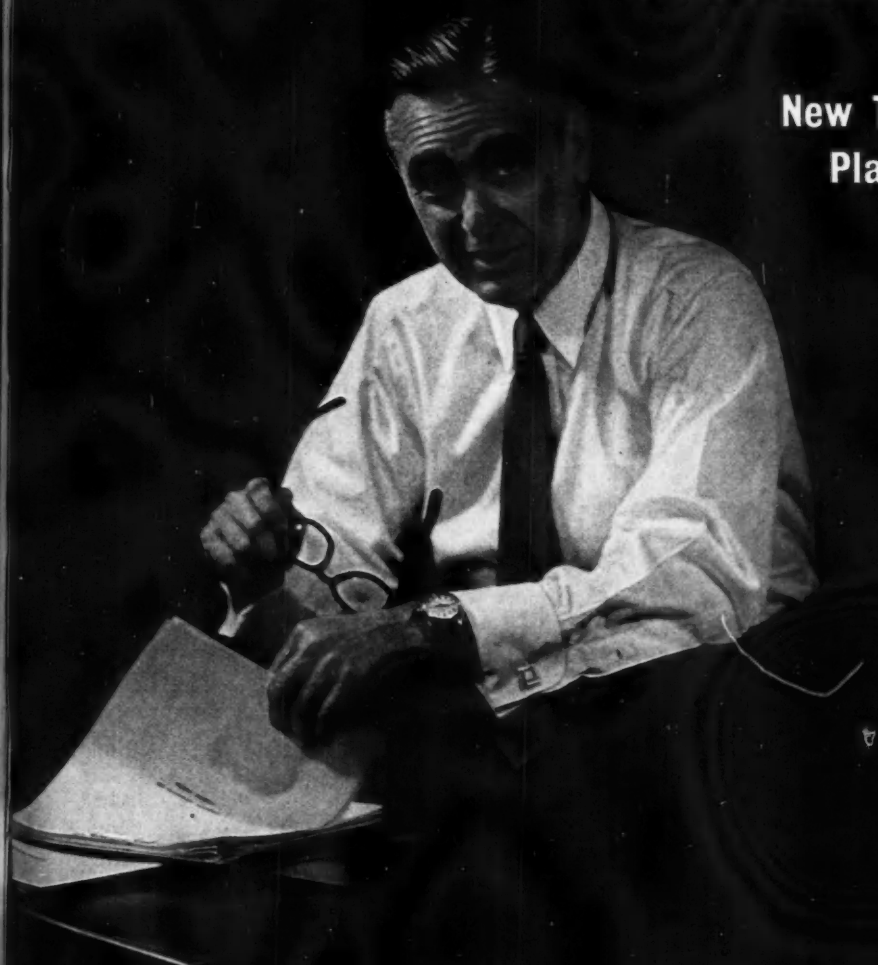
MEDICAL WORLD NEWS

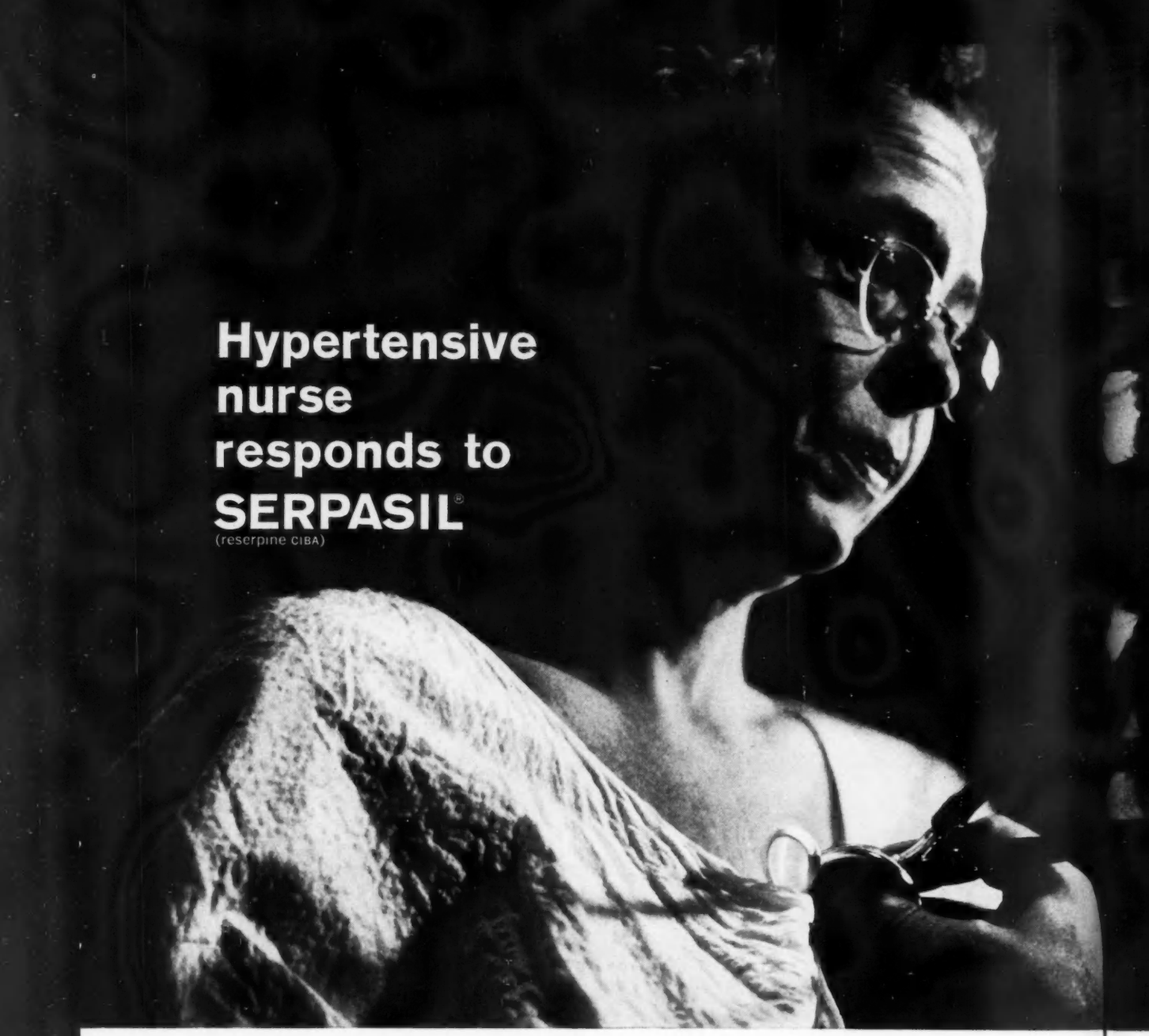
FEBRUARY 3, 1961

CHANGING PATTERNS OF X-RAY PRACTICE

New Technique Yields Platelets Unlimited



New Health Secretary Gets Down to Work



Hypertensive nurse responds to SERPASIL®

(reserpine CIBA)

Antihypertensive and calming effects produce good results

Mrs. E. Y., age 45, is active and vigorous. She is a happy woman with many interests: antiques, baking, knitting. Trained as a nurse, she has been married 18 years and, until 7 years ago when her husband was promoted, worked in a doctor's office.

On April 8, 1959 she had a complete physical examination. There was a history of "migraine" headaches—probably due to tension—slight weight gain, and minor gynecologic problems. Laboratory findings and EKG were normal. She had mild, essential hypertension.

Her physician prescribed Serpasil—0.25 mg. at bedtime. Blood pressure responded as shown in table at right.

Her physician reported: "In view of the slight blood pressure rise [after discontinuation of Serpasil] it is probable that intermittent Serpasil therapy will be necessary indefinitely."

Calmer and normotensive, Mrs. Y. notes: "With Serpasil I don't care that the furniture doesn't get dusted every day."

BLOOD PRESSURE RECORD OF MRS. E. Y.

April 8	150/110 mm. Hg
May 10	140/90
June 12	110/80
July 20	110/70
November 11	116/70
(Serpasil discontinued)	
December 12	140/80

2/2881MK

Photos used with patient's permission.

BLOOD PRESSURE THAT GOES UP WITH STRESS OFTEN COMES DOWN WITH SERPASIL®

(reserpine CIBA)

One reason that many cases of hypertension respond to Serpasil is that many cases are associated with stress. Stress situations produce stimuli which pass through the sympathetic nerves, constricting blood vessels, and increasing heart rate. Hyperactivity of the sympathetic nervous system may elevate blood pressure; if prolonged, this may produce frank hypertension. By blocking the flow of excessive stimuli to the sympathetic nervous system, Serpasil guards against stress-induced vasoconstriction, brings blood pressure down slowly and gently.

In mild to moderate hypertension

Serpasil is basic therapy, effective alone "...in about 70 per cent of cases..."*

In severe hypertension

Serpasil is valuable as a primer. By adjusting the patient to the physiologic setting of lower pressure, it smooths the way for more potent antihypertensives.

In all grades of hypertension

Serpasil may be used as a background agent. By permitting lower dosage of more potent antihypertensives, Serpasil minimizes the incidence and severity of their side effects.

*Coan, J. P., McAlpine, J. C., and Boone, J. A.: J. South Carolina M. A. *51*:417 (Dec.) 1955.

SUPPLIED: SERPASIL Tablets, 0.1 mg., 0.25 mg. (scored) and 1 mg. (scored).

Complete information available on request.

CIBA

SUMMIT · NEW JERSEY

VOL. 2, NO. 3

MEDICAL WORLD NEWS

THE NEWSMAGAZINE OF MEDICINE

FEBRUARY 3, 1961

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On the cover: Abraham Ribicoff, a political moderate and close friend of the President, begins the task of administering to the nation's needs in health, education and welfare. Story on p. 31

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attains
sustains
retains

extra
antibiotic
activity

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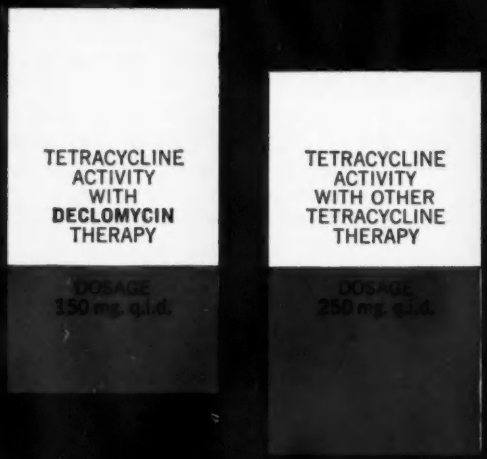
attains activity levels promptly

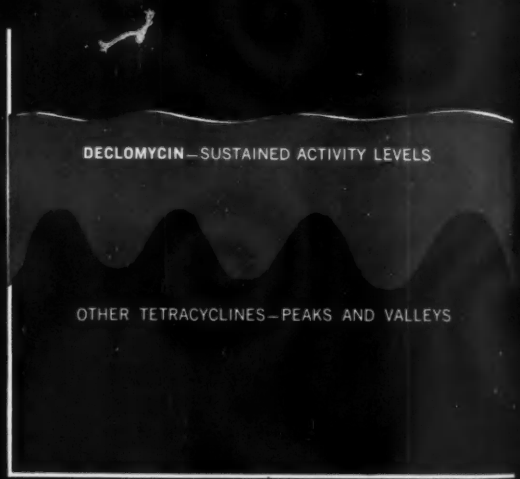
DECLOMYCIN Demethylchlortetracycline attains—usually within two hours—blood levels more than adequate to suppress susceptible pathogens—on daily dosages substantially lower than those required to elicit antibiotic activity of comparable intensity with other tetracyclines. The average, effective, adult daily dose of other tetracyclines is 1 Gm. With DECLOMYCIN, it is only 600 mg.

sustains activity levels evenly

DECLOMYCIN Demethylchlortetracycline sustains, through the entire therapeutic course, the high activity levels needed to control the primary infection and to check secondary infection at the original—or at another—site. This combined action is usually sustained without the pronounced hour-to-hour, dose-to-dose, peak-and-valley fluctuations which characterize other tetracyclines.



POSITIVE ANTIBACTERIAL ACTION



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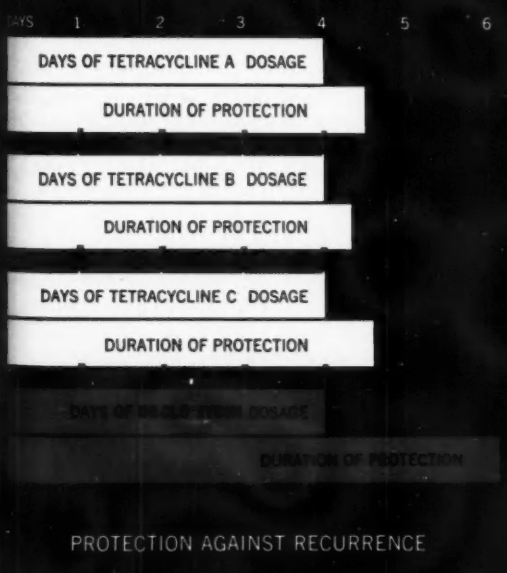
DEMETHYLCHLORTETRACYCLINE LEDERLE

retains activity levels 24-48 hrs.

DECLOMYCIN Demethylchlortetracycline retains activity levels up to 48 hours after the last dose is given. At least a full, extra day of positive action may thus be confidently expected. The average, daily adult dosage for the average infection—1 capsule q.i.d.—is the same as with other tetracyclines... but **total** dosage is lower and duration of action is longer.



CAPSULES, 150 mg., bottles of 16 and 100. **Dosage:** Average infections—1 capsule four times daily. Severe infections—Initial dose of 2 capsules, then 1 capsule every six hours.

PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz. **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

PRECAUTIONS—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under constant observation.

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LATE NEWS

MITRAL VALVE REPAIRED BY PERICARDIAL GRAFT

For patients who might not withstand open heart surgery, a new technique of grafting may provide the best repair of mitral insufficiency. It employs a four by five cm strip of pericardium inserted via the left atrium, looped through the defective valve, and attached to the myocardium.

A team of French surgeons have performed the operation on 15 dogs, producing efficient prostheses without inflammation or stenosis. Since the method does not require extra-corporeal circulation, they believe it might be particularly valuable in poor-risk patients—who are the ones most likely to need surgical intervention.

All of the experimental animals had artificially induced mitral insufficiency, confirmed by blood pressure studies. Examinations made 12 hours to 280 days after surgery showed that during the first 15 days the graft is not well attached to the myocardium. Later, however, it becomes incorporated in the heart tissue and is covered with a smooth endothelial layer. Motility of the valves is not hampered, according to Dr. E. Henry, head of the Laboratory of Experimental Surgery in Marseilles.

NEW ANTIVIRAL AGENTS HAVE PROMISING FUTURE

What are the prospects for a broad-spectrum viral antibiotic?

Research into three different substances is now reaching a promising stage, reports Dr. Igor Tamm of the Rockefeller Institute. Their common denominator is that they have significant selectivity of action—they inhibit virus multiplication without damaging the host.

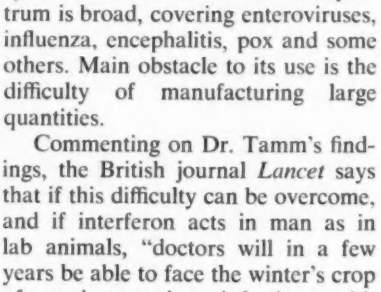
The first of the three is an antimetabolite (the hydroxybenzyl derivative of benzimidazole) which shows distinct antiviral activity for poliomyelitis, Coxsackie and ECHO viruses. This limitation to three viruses is considered an advantage, since it promises the possibility of "rifle accuracy" rather than the "shotgun" effect of most antimetabolites.

The second substance is helenine, a nucleoprotein recovered from a mold. It has shown protective action in experimental animals infected with influenza and encephalomyelitis, according to Dr. Tamm.

The third is interferon, which differs from the other two in that it is produced naturally by cells in response to infections. Its antiviral spectrum is broad, covering enteroviruses, influenza, encephalitis, pox and some others. Main obstacle to its use is the difficulty of manufacturing large quantities.

Commenting on Dr. Tamm's findings, the British journal *Lancet* says that if this difficulty can be overcome, and if interferon acts in man as in lab animals, "doctors will in a few years be able to face the winter's crop of respiratory-virus infections with more cheer than they can manage to muster today."

SMALL ORGANISMS STAR ON TV SCREEN



Now the waiting surgeon in the operating room can see a microscopic section of biopsied tissue at the same time it is being examined by the pathologist.

A new optical magnification system makes this possible by combining a microscope with closed-circuit television. The system gives a range of magnification between 2,000 and 5,000. Its developers, Elgeet Optical Company of Rochester, N. Y., also believe the device will be useful for classrooms where groups of students can simultaneously see what the teacher is examining under the microscope. The entire system, including standard TV set, is priced between $1,500 and $2,200, depending on magnification and resolution.

NEW JERSEY OSTEOPATH APPEALS LICENSE SUSPENSION

A New Jersey osteopath is petitioning the state to lift suspension of his license by the State Board of Medical Examiners which acted against him in December after 14 of his patients died and 30 others became ill, apparently of hepatitis.

The New Jersey Health Department said all of the patients had been given injections of sedatives by Dr. Albert Weiner, who specializes in psychotherapy and is acting chairman of the department of neurology and psychiatry at Philadelphia College of Osteopathy. His private practice in Camden, N. J., is said to number some 400 patients.

An investigation is now being conducted by the state to determine whether the illnesses and deaths were caused by serum hepatitis or the infectious form. Dr. Weiner, in asking that the suspension be ended, said the state has had "more than reasonable time" to complete its probe.

SWEDISH MD USES POLLEN SPORES FOR PROSTATITIS

Pollen, a bane to the allergic, may prove a boon for patients with chronic prostatitis.

Dr. Gosta Jonsson of the Lund University hospital used a pollen preparation *Cerniton* (Cornelle Company, Sweden) in the treatment of 25 patients with the disease over a two-year period. Patients became symptom-free and showed a normalizing of the prostate secretion and palpation findings.

The preparation is rich in amino acids and vitamins, and contains a tiny amount of estrogens.

OUTLOOK FAVORABLE FOR PRIMARY HYPOPARATHYROIDISM

Primary hypoparathyroidism has shifted from the "very rare" to the "not so rare" category. However, many cases still go unrecognized because diagnosis depends on indirect procedures to detect biochemical disturbances, according to Dr. B. E. C. Nordin of the University of Glasgow Medical Faculty, Glasgow, Scotland.

A more accurate method of diagnosis would be direct measurement of the hormone concentration in tissue fluid. Happily, a start has been made

in this direction, although further work on the purification and characterization of parathyroid hormone is needed to speed the development of such a direct procedure.

In the meantime, lacking a simple test, the practitioner can remain on the lookout for certain warning signs of excess parathyroid function: lowered serum phosphate and elevated phosphate clearance; osteoporosis; renal calculous disease and, as a cardinal feature, elevated serum calcium.

Most commonly, the disorder is linked to the presence of a single adenoma; the treatment is surgery, and the prognosis is immensely favorable with early diagnosis, he notes.

AMPUTATION RECOMMENDED FOR CHILDREN WITHOUT FIBULAS

When a child is born minus one of the long bones of the body, it is most frequently the fibula which is missing. Usually, the deformity is treated with plaster casts, wedging, manipulation under anesthesia or bracing.

However, it appears that the best thing to do is simply to amputate the leg and be done with it, say Drs. Leon M. Kruger of Springfield, Mass., and Richard D. Talbott, Watertown, Mass. The alternatives, they note, amount to "multiple hospitalizations, multiple anesthesias, multiple surgical procedures and an end result that leaves much to be desired."

On the other hand, children fitted with prosthetic limbs at Shriners' Hospital for Crippled Children in Springfield have quickly been able to bicycle, play baseball, skate and, in one case, even ski. Four indications for early amputation were cited:

Leg length discrepancy. Lengthening procedures on the deformed limb are seldom effective and discrepancies of several inches usually result.

Foot deformity. With a prosthesis, a child has normal gait.

Psychological benefits. The prosthesis is "cosmetically superior."

Economic considerations. Prosthetic limbs are expensive, but not as costly as the repeated hospitalizations required in other treatment.

"While it is true that a child with a platform brace or built-up shoe can do many things, he is looked upon as a cripple," says Dr. Kruger.

"We have observed some rather dramatic changes in the personality of the children" with prostheses.

EARLY ABDOMINAL DIAGNOSIS REDUCES CHILD MORTALITY

A "remarkably low" mortality rate of only 0.57 per cent in 1,406 emergency abdominal operations on children has been reported by the Royal Hospital for Sick Children, Edinburgh, Scotland.

The accomplishment is ascribed by Dr. J. J. Mason Brown to long-time emphasis on early diagnosis and to ultra-caution by physicians because of fear of malpractice suits. Patients now summon the doctor as soon as the child complains, and "frequent abdominal upsets no longer get a chance to settle down," he says. "Children may be hospitalized within one hour of the onset of pain."

Appendectomies accounted for 977 of the cases, which were seen from 1955 to 1959. There were no deaths among the 977, despite perforation of the appendix in 72 per cent of the patients under five and 26 per cent of the older group.

The Edinburgh surgeon notes that while appendicitis cases have been on the rise, hospital admissions for "abdominal emergencies" have increased much more sharply. In 1930, 79 per cent of cases referred as acute appendicitis underwent surgery; in 1960, less than 50 per cent.

While stressing the importance of early diagnosis, Dr. Mason Brown declares that appendicitis cannot be spotted "with certainty under 12 hours from onset."

FLUORESCENT STAINING AIDS CERVICAL CANCER SCREENING

Mass screening programs for early cervical cancer may be speeded up by a fluorescent staining technique worked out at the University of Minnesota Hospitals, Minneapolis.

The new method, developed by Drs. Franklin R. Elevitch and Joel G. Brunson, is simple and requires no special equipment. It is not as accurate as the conventional Papanicolaou test. But it has certain advantages; it is fast

CONTINUED

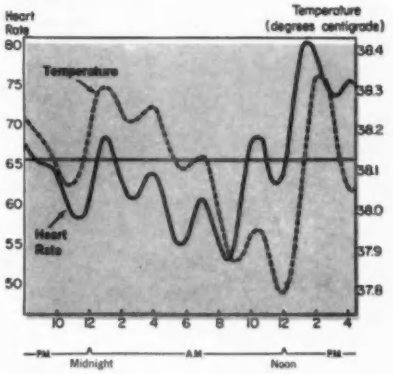
RADIO YIELDS NEW DATA ON HEART AND TEMPERATURE

In experimental research of physiological day-and-night changes in animals—especially that involving temperature and heart beat—researchers have been hamstrung by wires, tapes and awkward restraints.

These factors have undoubtedly influenced results, as indicated by a new study at the State University of Iowa. There a tiny radio device has freed both dog and man from these limitations and produced some new data.

Developed by Dr. Warren O. Essler, an electrical engineer at South Dakota State College, the device is smaller than the palm of the hand, weighs 37 gm and is capable of transmitting signals about ten feet.

Implanted in dogs by Dr. G. Edgar Folk, Jr., of Iowa State, the radiotelemetry device shows that the "true" heart rate of a dog at rest is about 25 per cent lower than that recorded in basic texts. Further studies with two devices—the second for temperature—indicate that body temperature and heart rate rise and fall together in any 24 hour period (see chart). What this



means is not clear, says Dr. Folk, but it suggests that these variables are more than just "fortuitous" barometers of disease and recovery.

Dr. Folk is now engaged in developing methods to use with patients, so that temperature and EKG can be transmitted from capsule radios attached to the skin, since "some patients in the past have been inclined to get entangled (at night) in the lead wires we ordinarily use."

and does not demand highly skilled cytoscreeners.

The staining technique is based on the striking red-orange fluorescence given off by malignant cells stained with acridine orange (AO). Staining takes six minutes and results in a polychromatic picture that can often be recognized even under low power. Screening requires only a standard microscope with an inexpensive ultraviolet light source and a yellow filter.

Results of screening 641 unselected gynecologic and obstetric cases in the Minneapolis area show the strength and limitations of the technique. The new method identified only seven of 12 malignant tumors. It missed two cases of recurrent post-irradiation squamous cell cervical carcinoma. Of the 18 AO fluorescent positives, malignancy was proven in only seven. But over half of the false positives occurred in patients with post-irradiation squamous cell carcinoma. Thus, the major limitation of the technique involves post-irradiation patients, while its main advantage is the speed with which it can pick up unsuspected or early squamous cell cancer—"the logical objects of mass screening programs."

LEUKEMIA TRACED TO CHROMOSOMES

Another type of leukemia can now be linked with a microscopic abnormality of the chromosomes.

Researchers at the University of Pennsylvania recently found what may have been the first consistent chromosome abnormality in leukemia (MWN, Dec. 2, 1960). Their findings were in patients with the chronic granulocytic type of the disease.

In the latest study, conducted at the British Medical Research Council unit in Edinburgh, 12 patients with the chronic myeloid type were found to have exactly the same kind of chromosome aberration, a foreshortening of the arms on the sites known as Nos. 21 and 22.

THE HOUSEHOLD SAFETY PIN BECOMES A SURGICAL TOOL

The Yankee ingenuity of two Boston physicians has turned the ordinary safety pin into a surgical tool.

To make a simple self-retaining retractor for small wound surgery, Drs. Leonard Braunstein and Melvin I. Shoul of Faulkner Hospital, Boston, sterilize a common safety pin, bend the tips outward at right angles to the limbs, then make a second bend in each limb of the pin (at right angles to the first bend).

The safety pin retractor, claim the inventors, avoids all the problems of the commercially designed retractors for small and superficial wounds. There are no bulky handles to serve as fulcrums to dislodge the retractor. There are no projecting parts for suture material to get tangled in. The retractor lies flat against the wound surface and is not easily dislodged unless the jaws are squeezed shut, the Boston surgeons comment.

NEW CRITERIA FOR EARLY DIAGNOSIS OF HYDROPS

The halo sign, the fetal fat line and the "Buddha" position — accepted landmarks of roentgenologic diagnosis of fetal hydrops—are often misleading, according to Dr. Paul A. Bishop of the Pennsylvania Hospital, Philadelphia.

In four of six cases he has studied, the fat line was completely obliterated and in two it was seen only very faintly along the back where the edema was less marked. Dr. Bishop reported at the annual meeting of the American Roentgen Ray Society in Atlantic City. Five of the six died, three of them before birth.

Descriptions of the halo sign, he pointed out, have often been conflicting, and the extremities of a normal fetus may frequently have the "Buddha" posture, which is important only in combination with other signs.

Some of the other signs he watches for: Elevation of the ribs because of the enlarged heart, pleural fluid and upward pressure of the distended abdomen; and spreading of the arms from the normal position of close contact with the trunk because of edema.

The Philadelphia radiologist uses both anteroposterior and lateral projections, with the patient lying on a Bucky diaphragm table. High speed film and intensifying screens are used to reduce radiation dose.

Roentgenologic examination should be performed when a pregnant woman is known to be Rh negative or has had a previous erythroblastotic baby. Reexaminations should be frequent enough to detect early changes that otherwise may be unrecognized.

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lowers blood pressure
drains excess water
calms apprehension

Now the most widely prescribed diuretic-antihypertensive, hydrochlorothiazide, is combined with the most widely prescribed tranquilizer, meprobamate. It is called "Miluretic", and constitutes new, effective therapy for hypertension and congestive failure — *especially when emotional factors complicate your treatment.*

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Antihypertensive agents derived from Rauwolfia often cause reactions such as depression and nasal congestion; Miluretic does not.

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Dosage: For hypertension, 1 tablet four times a day. For congestive failure, 2 tablets four times a day.

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A LETTER FROM THE PUBLISHER

Stop at any newsstand and the chances are that you will spot at least one magazine with a feature article on the drug industry. Looked upon with little interest by the general public until last year, the business of developing, producing and distributing pharmaceuticals has been thrust rapidly upon the stage of general awareness, even to the extent that some of its special vocabulary—phrases like "detail men" and "ethical drugs"—has become part of the public domain.

This change in awareness has been brought about largely by the recent Kefauver investigation, instituted for the express purposes of protecting the public welfare, helping to reduce drug prices and aiding the small drug manufacturer in competition with the big companies.

But if events stemming from the hearings continue in the direction they now seem headed, the results may be exactly the opposite of what the Senator from Tennessee intended. For example, at a recent medical convention, I ran into a pharmaceutical executive who pointed out that the already high cost of bringing a new product to market would be increased substantially if the Kefauver program were put into effect.

A story he told me from his own company's experience illustrated the impact of FDA "tightening up" in advance of new and contemplated legislation. A product on which his company had spent more than $300,000 in preparation, investigation and field testing, failed to satisfy the FDA which, he maintains, is "running scared." Now his company is spending another $100,000 on additional testing in order to get the FDA nod. In his opinion, the additional work will add practically nothing to the clinical evaluation of the safety or efficacy of the drug.

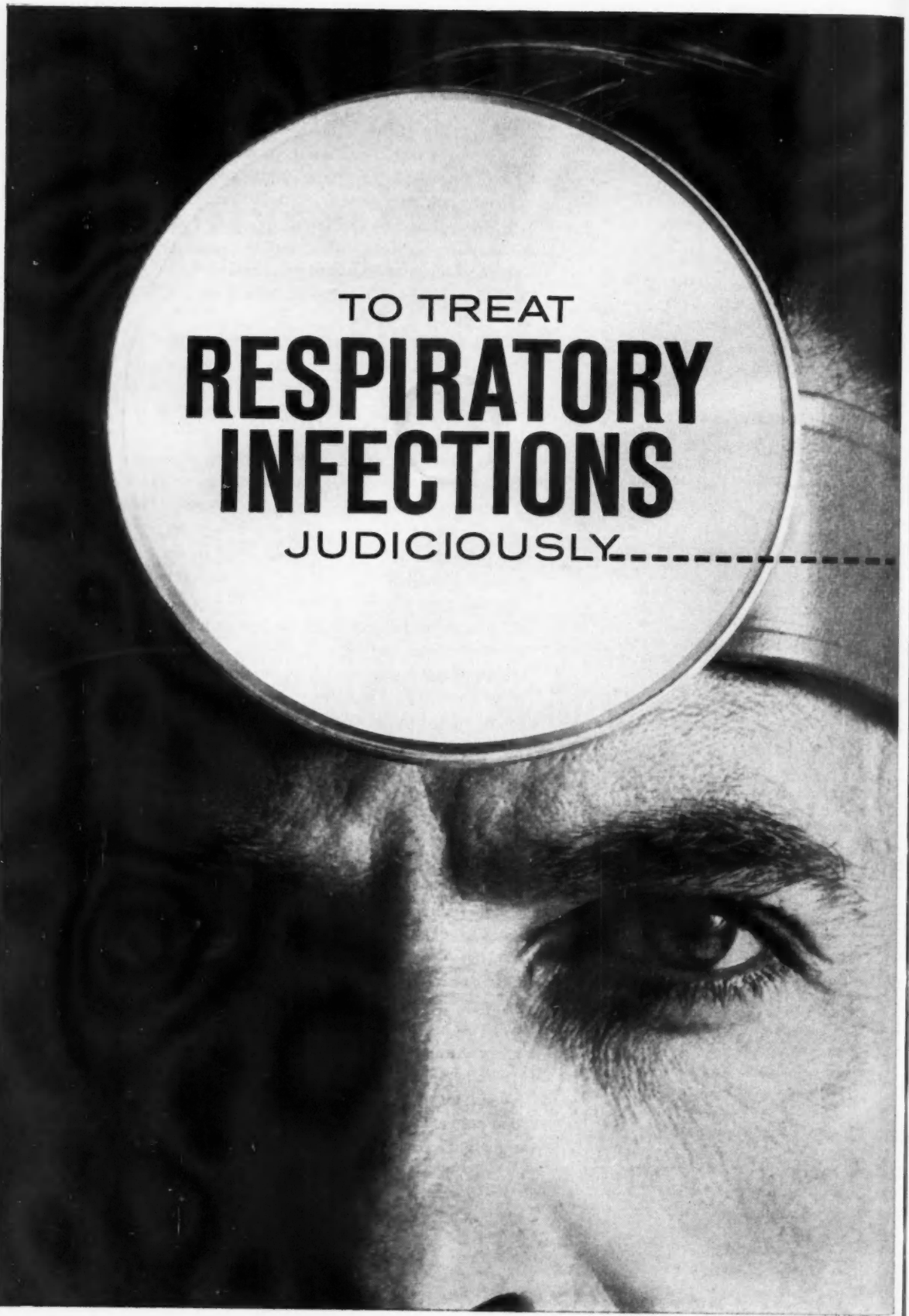
"How many companies," he asked, "can afford to spend $400,000 on *any* product? Hardly more than a few. And where does this leave the hundreds of small manufacturers who haven't a half million dollars in their entire development and research budgets?"

That's why, he argues, the forces set in motion by Sen. Kefauver ironically may be creating a situation which is the reverse of what anyone intended. In the long run, he feels, competition will be eliminated and the end result will be higher rather than lower drug prices.

Perhaps, he's overstating the case, but it offered a new twist which gave me pause for thought. This wouldn't be the first time that politicians have cried, "we're doing this for John Doe," when actually they may be doing him a disservice.

M M Geffen

Publisher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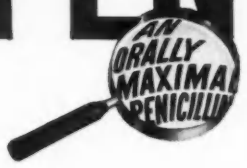

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Available as Maxipen Tablets, 125 mg. and 250 mg.; Maxipen for Oral Solution, 125 mg. per 5 cc. of reconstituted liquid.

Literature on request

or

When you hesitate to use penicillin
(eg. possible bacterial resistance or allergic patient)

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TAO®

triacetyloleandomycin

Extends the Gram-positive spectrum of usefulness to include many staphylococci resistant to one or more of the commonly used antibiotics... *narrows* the spectrum of side effects by avoiding many allergic reactions and changes in intestinal bacterial balance.

Available as Tao Capsules, 250 and 125 mg.; Tao Oral Suspension, 125 mg. per 5 cc; Tao Pediatric Drops, 100 mg. per cc. of reconstituted liquid; Intramuscular or Intravenous as oleandomycin phosphate. Other Tao formulations also available: Tao®-AC (Tao, analgesic, antihistaminic compound) Tablets; Taomid® (Tao with Triple Sulfas) Tablets, Oral Suspension.

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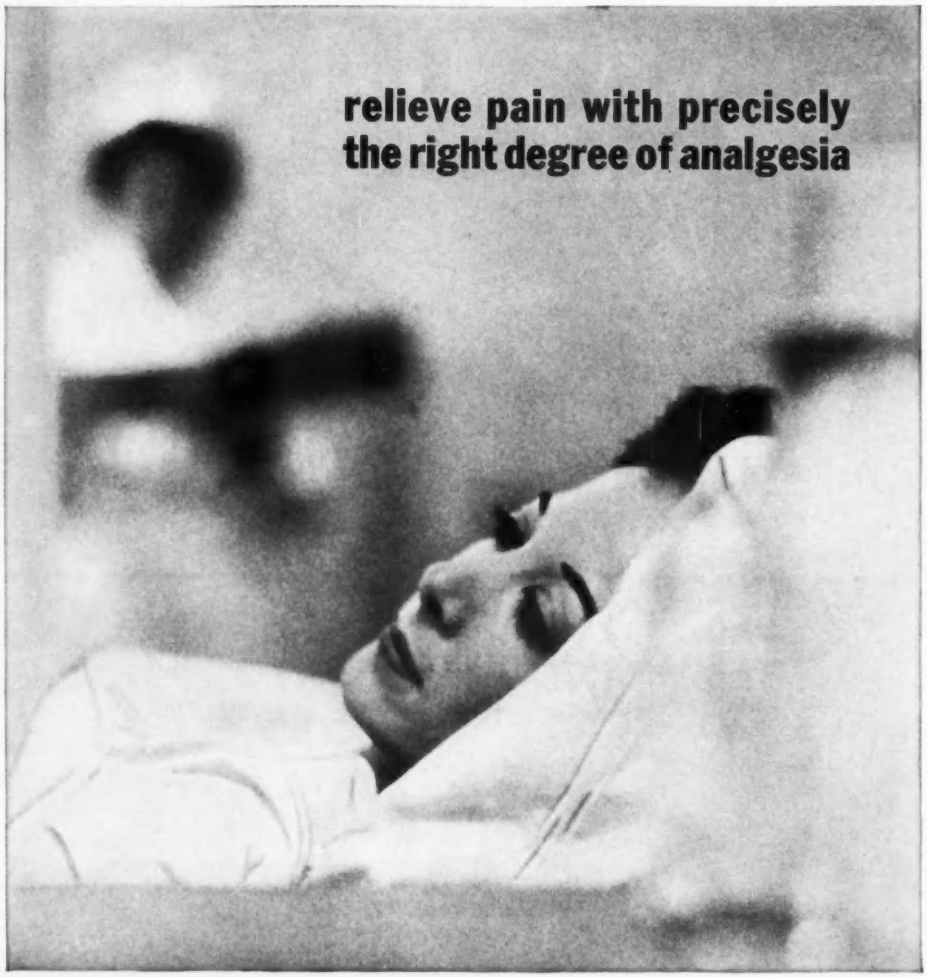

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OUTLOOK

- New Jersey MDs ask for "Good Samaritan" law
- Hunt for unsuspected carriers of galactosemia

A search is underway for unsuspected carriers of the gene defect that causes galactosemia and mental retardation. Dr. David Yi-Yung Hsia and colleagues at Northwestern University will use their new chemical test on 2,000 normal blood donors at Children's Memorial Hospital, Chicago, in what they call "one of the first attempts to determine, with biochemical methods, the distribution of a recessive gene in a human population." The Chicago team sees the results "as a basis for future efforts to control hereditary disease and congenital malformations."

Four major drug firms—Parke-Davis, Abbott, Pfizer and Merck Sharp & Dohme—have agreed to join a committee to advise the State of California how to reduce its $12 million annual drug bill for welfare patients. Two wholesale drug firms and members of the California Pharmaceutical Association have indicated a willingness to forego a portion of their profits in dispensing drugs to welfare patients.

New Jersey physicians are seeking state legislation similar to California's so-called "Good Samaritan" law. Its object: to make doctors who render first aid at the scene of an accident immune from civil damage suits.

The Atomic Energy Commission will seek the advice of leading scientists on the radiation processing sometimes used to preserve refrigerated foods. A committee of the American Institute of Biological Sciences plans to make recommendations on low-dose radiation processing of specific marine, fruit and vegetable products.

A massive three-volume "Index Handbook of Cardiovascular Agents" is going to make it easier to search the literature in this broad field. The National Academy of Sciences-National Research Council has already brought out volume two; the full set, to be ready within two years, will cover literature from 1931-60. For the first published volume, research staffers searched 13,427 scientific papers in 20 languages, compiled 100,000 alphabetical items. It's available, for $15, from NAS-NRC in Washington.

Charging that Blue Cross and Blue Shield in his state are "reckless with administrative expenses," the chairman of the New York State Committee on Insurance wants the plans investigated. Republican assemblyman Lucio Russo declared that pay raises at Blue Cross came to $700,000 in 1960 and that Christmas bonuses paid by the two plans totaled $725,000. In view of recent state-approved rate increases, Russo has called for an inquiry either by a special legislative committee or his own Insurance Committee.

The nation's health science manpower needs will be surveyed by the Federation of American Societies for Experimental Biology. The overall project, launched by the middle of the year, will be supervised by the University of Pittsburgh and will require from three to five years to complete.

The Connecticut Legislature is considering a law designed to insure a steady supply of GPs for the state. The proposal, if approved, would make available loans of $2,500 a year for four years to ten Connecticut medical students annually. Each student would agree to engage in general practice in the state for five years before being asked to repay the loan.

Twice as many students will be graduated by California's medical schools within another ten years—if the State Legislature approves a proposed $93 million building program. At the heart of the proposal: a new medical school to be built at San Diego.

MEETINGS

Feb.	14	N. Y. Assoc. of Industrial Nurses, New York City
Feb.	16-18	Central Surgical Association, St. Louis
Feb.	23-25	Amer. Acad. of Forensic Sciences, Chicago
Feb.	28	Colorado State Medical Society, Denver
Mar.	6-9	Southeastern Surgical Conference, Miami Beach
Mar.	6-9	New Orleans Graduate Assembly, New Orleans
Mar.	6-9	American College of Surgeons, Philadelphia
Mar.	7	Symp.: "Mechanisms of Gastrointestinal Absorption," New York City
Mar.	8-11	Neurosurgical Soc. of America, Boca Raton, Fla.
Mar.	9-11	Eastern Conf. of Radiology, Baltimore
Mar.	12-17	American College of Allergists, Dallas

UPCOMING

April	17-20	Amer. Acad. of General Practice, Miami Beach
April	24-26	Aerospace Medical Association, Chicago
May	7-11	Int'l College of Surgeons, North America Federation, Chicago
June	3-15	International Medical-Surgical, Turin, Italy

MEDICAL WORLD NEWS
February 3, 1961 Vol. 2, No. 3

NEW SINGLE-DONOR TECHNIQUE YIELDS PLATELETS UNLIMITED

One man can safely give 32 times more platelet-rich plasma for leukemia therapy when red cells are put right back into his circulation

Scientists at the National Institutes of Health have successfully tested a new technique which enables a single blood donor to be bled repeatedly over a short period of time, providing massive transfusions of fresh platelet-rich plasma for leukemic patients—thus doing the work of dozens of donors.

They simply return the red blood cells to the donor's circulation immediately after removing the platelets. Thus, they eliminate the long delay needed between donations to enable the red blood cell count to climb back to normal.

According to Dr. Allan Kliman of NIH's division of Biologics Standards, the technique promises significantly safer and more effective treatment of hemorrhagic tendencies in leukemia, as well as a 32-fold increase in the efficiency of blood donor utilization.

In trials with the technique, six donors serving six leukemic children produced 26.5 liters of platelet-rich plasma. If conventional techniques had been used, the same yield would have required 106 donations.

With the new method, a single donor can be bled twice at one time or four times a week, giving as much as a liter of platelet-rich plasma. The process can be repeated without observable depletion of protein or blood cells. In the case of conventional methods the Red Cross permits a donation of only one pint every two months, or five pints a year. Over a two-month period, this would mean about 250 cc. In the NIH study, however, single donors gave as much as 8,000 cc in the same period.

One of the major problems in the treatment of thrombocytopenia, Dr. Kliman points out, has been administering large quantities of platelet-rich plasma or blood from pooled supplies. Some investigators have felt it is impossible to transfuse sufficient quantities of platelets fast enough to produce a significant effect. There has also been evidence that in some patients platelets are destroyed.

In addition, pooled plasma or blood has carried the risk of hepatitis, and the need for a great number of donors and donations to maintain even a single patient has proved a heavy burden. Above all, doubts have arisen whether the therapy really has raised platelet counts.

Dr. Kliman and his group decided that a breakthrough might be achieved by using the technique of returning the red cells to the donor to increase his capability. The method, employing plasmapheresis, had previously been used by other researchers to prepare hepatitis-free plasma and to obtain commercial lots of clinically important antibodies. But it had not been tried for leukemia cases, and the equipment used was both cumbersome and complex.

The simplified system developed by the NIH researchers employs plastic equipment throughout. Blood is drawn off through a phlebotomy needle into a whole blood container. An elevated plastic bottle carries saline solution which keeps the tubes air-free until platelets are returned. The platelets are separated from the red cells by centrifugation. The packed red cells are then fed back through the tubes into the circulating blood of the donor while platelets are removed for separate transfusion into the leukemic patient. Within seconds, bleeding can be repeated, using the same needle. The entire process—including two full donations of up to a liter—takes less than an hour.

Reporting his findings to the eastern section of the American Federation for Clinical Research, Dr. Kliman said the system carries built-in guarantees against air emboli and contamination. His group has performed the technique about 1,000 times with no detectable depletion of blood proteins among the donors.

The Biologics Standards team worked with a group

CONTINUED

DR. KLIMAN helped perfect way of harvesting platelets.

of National Cancer Institute investigators on the leukemia-patient tests. They are Drs. Emil J. Freireich, Lawrence A. Gaydos and Leslie R. Schroeder.

Experience with the six reported patients showed that when platelets are obtained quickly in large quantities and then transfused while they are still fresh, they unequivocally raise platelet counts.

Although all six leukemia patients had counts of less than 10,000 before a transfusion, they had sharply increased levels afterward. The peaks averaged about 40,000 and one hit 156,000. The counts then dropped back down gradually over a period of about three days.

Hepatitis Danger Reduced

Each donor, since he is assigned to a single child, can be typed carefully to reduce or eliminate the problem of immune reactions. Furthermore, the chance of hepatitis infection can be reduced to the minimum. Neither of these important conditions can be met with pooled plasma.

If the technique will assure increased platelet counts, then clinicians might be able to push chemotherapeutic regimens higher in the hopes of achieving better results. One of the main limitations of such therapy at the moment is the fear of uncontrolled hemorrhaging.

Reducing Plasma Needs

National blood authorities have called the new method "extremely promising," both from the viewpoint of leukemic therapy and the efficient use of donors and blood. It also provides a good means of studying the still little-understood platelets. And it may be useful in segregating blood components in other conditions, such as macroglobulinemia, where excessive amounts of abnormal protein leads to pathology.

The technique is also adaptable for use by conventional blood banks and if it were widely employed, authorities believe it could greatly reduce the need for the blood now used in the production of plasma. At present, the red cell residue in plasma is simply being thrown away, a cheaper method than the new process, simple and fast as it is. ■

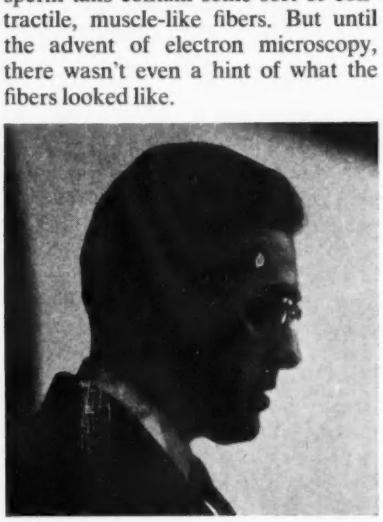
NEW FIBER THEORY GIVES CLUE TO SPERM MOTILITY

An answer to the old question of sperm movement may lie in a 9 plus 2 fibril pattern found in many plants and animals

There is something peculiarly humbling about a spermatozoon frantically whipping across a microscope slide at 3 mm per minute like a homunculus with a purpose.

What makes it move?

It had long been speculated that sperm tails contain some sort of contractile, muscle-like fibers. But until the advent of electron microscopy, there wasn't even a hint of what the fibers looked like.



DR. FAWCETT probes 'intriguing mystery.'

Even then, electron microscopists' first observations in the 1940's proved conflicting. They agreed that there must be more than one fibril, but their counts varied anywhere between eight and 24. Among the microscopists were two Australians who described the filament complex as two central fibrils surrounded by nine outer ones. That was in 1949.

Today, gametologists have shown that the Australians—G. W. Grigg and A. J. Hodge—had seen not only the basic architecture of the sperm tail, but had described a structure that is found with amazing consistency throughout the human, animal and plant kingdoms: the "9+2" pattern. And though sperm tails have kept many of their secrets, gametologists have been able to draw a logical blueprint of how they might work.

The 9+2 pattern is an arrangement of fibrils found in the tail of all spermatozoa, including man's; in the flagella and cilia that cover certain epithelial cells (as in the human trachea); in the reproductive system of some plants; and down the scale of life to the cilia on the skin of the unicellular paramecium.

Running along the center of each cilium or flagellum are two distinctly separate fibrils, parallel to each other. Nine double fibrils, each like twin shotgun barrels, are lined up at regular intervals in a circle around the two central fibrils. They are also parallel to each other and parallel to the central fibrils.

Wheel Spokes and Arms

In addition to these constant features, present studies are revealing refinements. In the cross section of some flagella, for instance, nine barely visible dense lines extend like wheel spokes from the central fibrils to the nine double fibrils. In the sea urchin and in the sperm tails of several mammals, pairs of short "arms" have been found to project from one of the nine double fibrils to the next. In a cross-section, viewed from the base to the tip of the sperm tail, these arms always project clockwise, as if reaching out for the nearest fibril.

In some larger spermatozoa, such as man's, an additional outer row of nine thicker longitudinal fibrils are found. This pattern is sometimes called the "9+9+2."

An abundance of new findings has led Dr. Donald W. Fawcett, professor of biology at Harvard University, to suggest a solution for the periodic debate of whether spermatozoa tails whirl in three dimensions like a ship's screw, or wriggle on one plane like a snake.

Cambridge University's Lord Rothschild had observed that the somewhat flat heads of bull sperm flashed under the microscope; he concluded that this resulted from rotation of the head and helical motion of the tail. But, Dr. Fawcett says, recent observations indicate that sperm tails

bend only one way—at right angles to a line running perpendicularly to the tail across the two central fibrils of 9+2, and that spermatozoa appear to move in two dimensions, reaching only slightly into the third, mainly at tail's end.

Another Britisher, Sir James Gray, also believes the motion is mainly in the plane, and that Lord Rothschild's view of the flashing head results from a "rock-and-roll" by the sperm head, not rotation.

Thicker Filaments Have Choice Positions

An even newer piece of evidence supports the planar movement theory. Two of the three thickest outer filaments found in larger sperm tails are invariably located directly opposite the third one, across the line around which the sperm tail apparently "beats." Mechanically, this would be the logical position for two-dimensional motion, says Dr. Fawcett. "It would be nice to believe that the two thick fibers on one side are concerned with the tail's active motion, and the single thick fiber, with recovery."

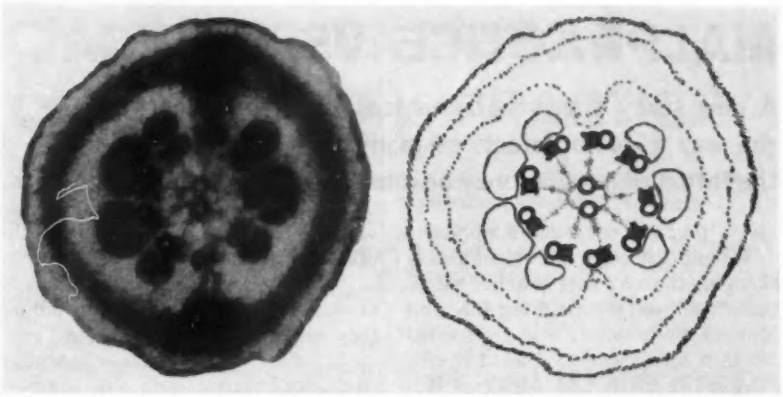
The remaining six outer coarse fibers, Dr. Fawcett adds, sometimes disappear as the tail thins out. They fade in a sequence that fits with the planar motion theory: the least useful ones end first, while the three thicker ones extend to the whiplash tip of the tail.

New evidence also has been provided against one of the neatest theories of tail motion, he says. The hypothesis was that the central pair of fibrils whirled inside the tail, and that the projecting "spokes" rattled across the nine double fibers, activating them one after the other. "Unfortunately for that theory, it just doesn't seem that the central fibers can whirl," according to the Harvard biologist.

Explanation in Chemistry

A more recent hypothesis is that the outer fibers slide along the central one in such a way that they shorten one side of the sperm tail and then the other, creating a wavelike movement. Another is that the double-barreled fibrils slide one against the other, perhaps activated by reactive sites on the "arms" that protrude from fiber to fiber. None of these has received final acceptance.

"One thing is very likely," says Dr. Fawcett: "The fibers are contractile fibers. Yet no sliding action similar to that described in Huxley's theory of muscle action (MWN, Jan. 20) can be shown to occur in flagella fibrils." He adds cautiously, "any conclusion now would be premature. The ultimate explanation of the mechanism lies in the chemistry of the components."



SPERM TAIL shows 2 central plus 9 surrounding fibrils, with extra thick outer fibrils (above). In longitudinal view (below) mitochondria line up along fibrils.

From the chemist's viewpoint, it is likely that spermatozoa derive much, if not all, of their energy from the mitochondria surrounding the middle-piece, and that adenosinetriphosphate (ATP) plays an important part in the process.

ATP action in the sperm tail, however, appears to be oddly different from ATP action in muscles. Filaments of bull sperm preserved in glycerine have been "revived" by ATP and, like muscle fibers under ATP action, they contract. But while muscle fibers contract once and remain contracted, sperm tail fibers keep pulsating for as long as an hour.

French biochemist Pierre Gonse worked on the problem of sperm energy supply in Dr. Britton Chance's lab at the University of Pennsylvania School of Medicine and has concluded that while ATP is the basic energy source, it apparently works anoxically by glycolysis, a method some 15 times less efficient than oxygenation.

Even mathematicians and engineers are now tackling the problem. Sperm motion has long been likened to the swimming of fish, though it may actually be totally different. Fish rely for propulsion on the inertia of surrounding water, microorganisms depend on the viscosity of their "seas." Some formulae have emerged that indicate a relationship between energy dissipation and the square of the cell's velocity. F. D. Carlson of Johns Hopkins has drawn up an esoteric series of equations showing that in some cases hypothetical cells have to keep moving through a nutrient medium in order to survive—but must not move too fast; and in some cases, they will live even if they stay put.

Whatever the means applied to solve the 9 + 2 equation, an answer is likely to shed light not just on matters of fertility, but possibly on the evolutionary process of life as well, Dr. Fawcett believes. A hint of the importance of this biological equation is seen in the recent revival of the theory that even visual pigments in vertebrates have arisen from the modification of cilia, and that in some lower organisms, 9 + 2 cilia play the part of primitive eyes.

Any conclusions about the meaning of 9 + 2, says Dr. Fawcett, should be viewed with caution. "The evolutional and functional significance of this universal pattern is still an intriguing, well-guarded mystery." ■

MALPRACTICE VS MEDICAL PRACTICE

A new study shows how the fear of litigation can change the way a doctor practices medicine—even though the threat of lawsuits may be more imagined than real

As a precaution against malpractice suits, doctors are significantly changing the way they practice medicine. Just how they are doing this, and some of the reasons for it, are spelled out in a study just completed by the Boston University Law Medicine Research Institute.

Candid comments on malpractice by 214 Massachusetts physicians indicate that doctors now routinely alter or modify even accepted common procedures to protect themselves against potential litigation.

A key question asked the 214 MDs was: Do you think the threat of malpractice suits is greater now than it was five years ago?

"A considerable number of physicians seem convinced that patients are suing their doctors at a greater rate than ever before," says clinical psychologist Robert L. Geiser, who conducted the study.

"This in spite of the fact that here in Massachusetts the number of malpractice cases brought to court is apparently on the decline."

Massachusetts, Geiser says, ranks 15th among the states in incidence of malpractice suits, and it rarely reports the kind of single judgments handed down in such states as California, which contributes a large share to the annual total of nearly $50 million in malpractice costs. Nevertheless, Massachusetts doctors apparently are as worried as anyone.

"Like Everest, the threat is there," Geiser comments, "and doctors tell us they only ignore it at their peril."

In the Law-Medicine Institute study, for instance, both general practitioners and specialists agreed they're now reluctant to accept certain types of patients for treatment.

Any patient known to have previously sued a physician leads the "undesirable list" of both groups of practitioners. Next come the "shoppers" who switch around from one doctor to another. Close behind are alcoholics and bad credit risks. Some respondents say that if a patient is suit-prone—if he's known to have sued his landlord or a neighborhood merchant—he'd better be directed elsewhere.

Self-imposed Limits

Some GPs voluntarily limit their scope of practice as a hedge against malpractice troubles. Many of them no longer attempt minor surgery or assist in surgery in any way. And many others won't handle their own x-ray work or fracture cases any more, according to the survey.

Chemotherapeutic procedures also are affected, although to a lesser degree. A few Massachusetts physicians say they now prefer to stick to the older, more widely-accepted drugs, even if some of these drugs are demonstrably less effective than some of the newer products.

Massachusetts physicians are also sharply stepping up their use of x-rays and laboratory analyses. Their reason is invariably the same: to have a tangible record at hand in case some patient should decide to sue. Even though the effect of routinely using these procedures means higher cost to the patient, the majority of respondents let their own practical considerations win out over sympathy for the patient's economic problems.

Greater Care, Less Risk

Another trend among Bay State GPs is an increased use of consultations with specialists. One physician said he calls in one or more consultants in any case where the end result might be poor—even though he is well aware that poor outcome of treatment is not sufficient basis for malpractice action.

There is a growing insistence that more and more things, even trivial ones, be put in writing. Many doctors say that keeping detailed histories and treatment records is particularly important in the case of an "uncooperative" patient. Other examples of routine paper work followed by many physicians: consent forms for treating minors, appointment cards for everybody, autopsy permits, written prescriptions instead of phone calls to the druggist.

The BU study shows that Massachusetts physicians share at least one

SIX SAFEGUARDS AGAINST A MALPRACTICE SUIT

Here are some procedures Massachusetts MDs say help cut odds on being sued

Routinely seek consultation with specialists

Tactfully avoid alcoholics, credit risks, 'doctor shoppers'

Put things in writing 'just for the record'

Refuse to diagnose or prescribe by telephone

malpractice-born characteristic with their colleagues in most other parts of the country. They have a marked distaste for appearing on the witness stand. Whether they think such appearances are "unpleasant," "embarrassing" or "too time-consuming," most confess they think twice before volunteering an opinion in court—and 25 per cent said they flatly refuse to appear unless subpoenaed.

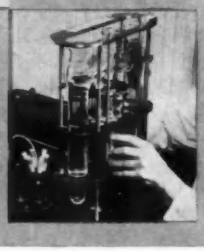
When asked whether the frequency of malpractice suits in a particular geographical area influences a physician's decision to move to this area, 71 per cent of Bay State physicians said it would.

Some Legal Suggestions

Many doctors, however, believed a solution might be found in abolishing lay juries in malpractice cases. As a substitute, they usually suggested that some form of medico-legal group handle the problem: an all-physician jury, a mixed jury of physicians and attorneys, special judicial boards trained in both medicine and law and "medically qualified" fact-finding committees. Some doctors even suggested court-appointed boards such as those used in settling industrial compensation cases.

But not all the replies reflect complete pessimism. Many Massachusetts doctors say they're convinced that well-informed, satisfied patients seldom sue. Because of this, a substantial number report that they're doing their best to explain fully a patient's illness and its method of treatment. One doctor summed it up: "Because of the malpractice threat, I take great care in what I do, what I say, how I say it." ■

Keep more detailed office and hospital records—just in case



Require more than routine lab tests

CHANGING PATTERNS OF U.S. X-RAY PRACTICE

Survey of dermatologists shows that selectivity, not fear, is behind the reduction in use of radiation for skin conditions

Radiation treatment of skin diseases has been reduced considerably in the past decade, not because patients or doctors are afraid of x-ray, but because physicians throughout the country have learned when and when not to use it.

These are the implications of a unique nation-wide survey conducted by dermatologist David G. Welton of Charlotte, N. C., with the aid of Dr. Bernard Greenberg, professor of biostatistics, University of North Carolina School of Public Health.

Ionizing radiation, they found, is used for an average of 23.1 per cent of all skin conditions. Superficial x-ray accounts for almost all use, with Grenz ray, thorium X and radium making up only 2.1 per cent of therapy.

Despite heightened public consciousness of radiation, doctors surveyed report little apprehension of radiation among patients. In only 3.9 per cent of all cases is x-ray avoided because of patient fear.

No Abundance of Data

A wide range of diseases are being treated with irradiation. Most frequently irradiated cases are those with keloids, anogenital pruritus, neurodermatitis, eczematoid dermatitis, dyshidrosis, epithelioma, chronic dermatitis venenata, fungus infections, psoriasis, herpes zoster and, of course, the ubiquitous acne.

Six years ago, during a panel discussion at the American Academy of Dermatology, Dr. Welton first got the idea for his survey. Little was known, he realized, about in-office use of x-rays as opposed to that in teaching centers and Government facilities where data are abundant. On his own he organized the survey (paying for it himself at a cost of over $5,000), and enlisted the aid of Dr. Greenberg. They divided the country into five geographical areas and dermatologists into two age groups—those under 50 and those over 50. "I was anxious to see what effect length-of-practice had on therapeutic habits," the Charlotte dermatologist says.

Fifty board-certified dermatologists were picked from five areas and asked to check patient visits and treatment during four weeks out of the year. In addition to receiving 27,000 records, Dr. Welton personally saw each of the 50 dermatologists, fitting in his visits with his attendance at various medical meetings. Not one of the dermatologists dropped out during the entire survey, he notes.

DR. WELTON checked 27,000 records.

From these efforts emerged an unusual portrait of the dermatologist at work, differences in use of radiation in various parts of the country and of patterns of disease incidence.

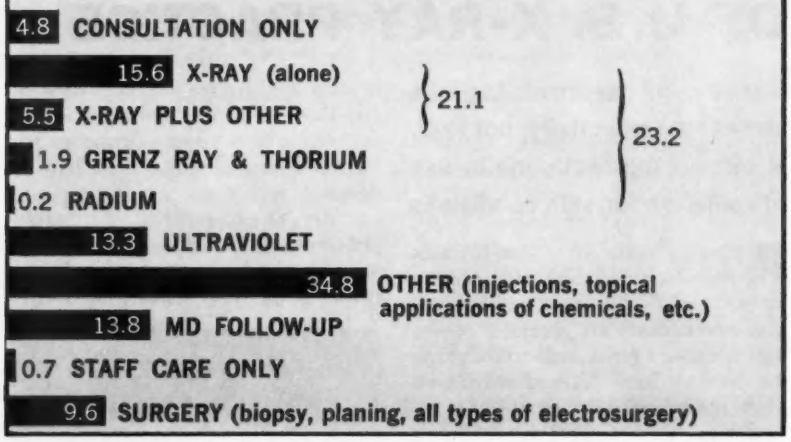
For example, Dr. Welton had frequently heard colleagues say: "The longer I am in practice, the less x-ray I use." This, he found, is true among Eastern dermatologists over 50. But the opposite is the case in the Midwest or West, where older men used radiation at "significantly higher" rates than younger practitioners.

Although the frequency of radiation use might change by age groups, the types of diseases in which it is used showed few variations.

Older specialists, Dr. Welton found, tend to use ionizing radiation more frequently than younger ones in treating acne, eczematoid dermatitis and warts. Younger men, on the other

CONTINUED

BREAKDOWN OF OFFICE PROCEDURES (26,986 CASES)



RADIATION USE IN AGE GROUPS

(Per cent in all services rendered)

AGE	Under 10	10-19	20-39	40-49	50-69	70+
X-RAY	5.6	18.3	21.9	22.1	24.5	26.6
GRENZ & THORIUM	0.4	0.8	2.1	2.8	2.2	1.7
RADIUM	1.5	0.0	0.02	0.02	0.2	0.2
TOTAL	7.5	19.1	24.02	24.92	26.7	28.5

RADIATION PREFERENCE BY AGE GROUPS

Used more often by young MDs for: seborrheic dermatitis, anogenital pruritus, chronic venenata, fungus, psoriasis

Used more often by older MDs for: dyshidrosis, keloid, acne, hemangioma

Used same by both groups for: atopic dermatitis, eczematoid dermatitis, epithelioma, keratoses, lichen planus, neurodermatitis, anogenital pruritus, pyoderma and warts.

PERCENTAGE OF CONDITIONS TREATED BY RADIATION

DYSHIDROSIS	39 Per Cent
LICHEN PLANUS	36
SEBORRHEIC DERMATITIS	20
PYODERMA	18
ATOPIC DERMATITIS	14

X-RAY CONTINUED

hand, use it more often for epithelioma, fungal infections (in the pregriseofulvin era), neurodermatitis, psoriasis, dermatitis venenata, seborrheic dermatitis and pyoderma.

Both groups use irradiation at about the same rate for keratoses. But older dermatologists use radiation four times more frequently for hemangioma than do their younger colleagues.

As an example of the widespread agreement about the advisability of x-ray for particular conditions, Dr. Welton points out that it was used in only 26 per cent of all patient visits for acne care; three-fourths of the cases were not irradiated. This, he emphasizes, "resulted from the physicians' individual and collective recognition of indications and contraindications."

A large number of dermatological patients are young people. Those between 10 and 19 account for 18.8 per cent of all visits.

Acne leads the list of common complaints among patients. It is the most frequent in all regions except the Southwest, where it is slightly overshadowed by epithelioma—a result, probably, of widespread exposure to sunshine, Dr. Welton comments. In the Midwest, on the other hand, acne is at its peak; it accounts for one case in every five.

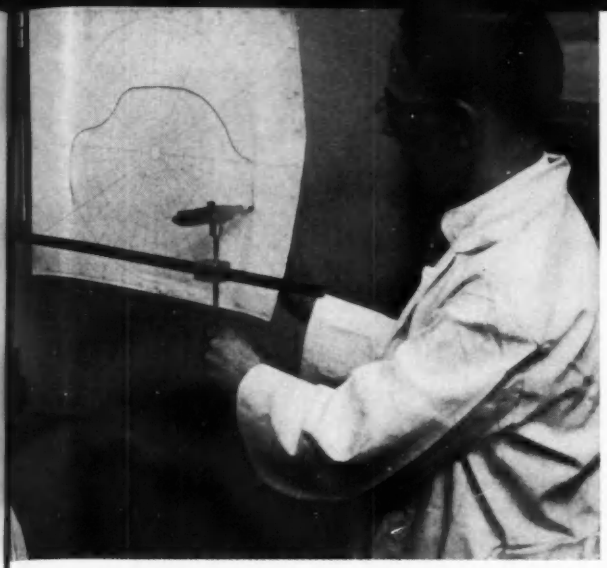
Uniformity of Practice

Other frequent complaints are eczematoid dermatitis (second most common diagnosis) warts, fungus, neuordermatitis, psoriasis and keratoses.

Epithelioma, third in frequency, ranges widely in incidence from a low of three per cent in the Midwest to 16 in the Southwest. Warts are more abundant in the Midwest and Northeast than elsewhere.

Concludes Dr. Welton: "There is a startling uniformity of practice as to radiation use in specific diseases. . . . There is a rather consistent uniformity of opinion as to the specific diagnoses for which it should be used.

"In general, the most consistent and effective limiting factor in the frequency of its use is the physicians' adherence to established policies regarding proper indications. The number of these indications continues to decrease steadily." ■



CONTOUR MAP of patient is made on plastic polar grid.

DOSAGE for deep tumor is set by matching grid to tables.

QUICKER WAY TO FIGURE X-RAY DOSE

Dr. James E. Turner, an instructor in radiology at Northwestern University Medical School and therapeutic radiologist at VA Research Hospital, Chicago, is tracing a physical outline of a patient on a special plastic transparency. By correlating the tracing with special tables, he quickly selects x-ray dosage figures matched to the individual's outline, the site of deep-seated tumors and the arc of treatment. His method is ten to 40 times faster than those currently used for dosage calculation in rotational x-ray therapy.

Before developing this rapid technique, Dr. Turner studied 22 systems for rotational therapy. He finally elected a combination of grids and charts designed by two physicists, K. C. Tsien of New York Memorial Hospital and Babette Stern of England.

Dr. Turner traces the patient's body contour onto a polar grid developed by Tsien, which resembles a map of the North Pole and Arctic Circle. He then applies scales worked out by the British physicist to estimate distribution of the radiation of the x-ray beam, the degree of scatter and tissue absorption at various distances from the source and center of the beam.

Dr. Turner takes the Stern scales and, by a mathematical formula, applies them to each of 469 points of the body from 36 directions. Thus he finds the proper dosage for each point. Once Dr. Turner's tables are completed, a technician or assistant will be able to handle the technique easily. For example, the technician will be able to figure dosages at ten crucial points in seven to ten minutes for the average case. In contrast, estimating doses at present requires up to 40 minutes per point.

Patients Contour Selects Dose

After tracing the patient's outline and axis position, skin-to-axis positions are read off every ten degrees along the treatment arc. These positions are then recorded on a second transparency by underlining the appropriate figures on a "skin position sheet."

Then the second transparency is placed over a dosage sheet, with an arrow pointing toward the polar coordinate value of the point to be dosed. The underlined figures are added, and then divided by the number of underscored lines, to provide the proper tissue dose.

"In essence," says Dr. Turner, "the patient's own contour automatically selects the figures pertinent to the dosage point and the radiation technique."

The Chicago radiologist is now preparing calculations for 250-200 kv x-ray machines, the type of facility used in small towns in America and Europe. Later he plans to prepare tables for cobalt-60 machines; centers with such units are likely to be able to estimate dosages and may have a physicist to do the calculating.

"The dose-finding technique is particularly applicable to medium voltage x-ray treatment of cancers deep inside the body," Dr. Turner points out. Moreover, rotational therapy permits a dose to the tumor several times heavier than to the skin, whereas in stationary x-ray therapy, the tumor gets only 20 to 30 per cent of the skin dose.

In treatment of deep cancers, two to six x-ray beams must be crossfired from several directions to give the tumor a dose larger than that given the skin and normal tissues. Labor is lightened and aim improved by rotational therapy, in which the tumor is centered just once and the x-ray beam moves over the patient in an arc, thus producing more efficient tumor doses than multiple beam crossfire.

When Dr. Turner is finished with his calculations, he will have amassed data (16 tables) for 36 beams, 16 beam sizes and 469 points of the body—five readings for each point—all of which eventually should simplify dosage calculations and encourage more frequent use of the rotational technique.

ELECTRONICS DIAGNOSE MENTAL ILLS

Russian psychiatrists find that impulses from the brain can produce topologic mosaics. Comparative studies show these patterns vary with the severity of mental disease

Russian psychiatrists say they have diagnosed schizophrenia by an electronic test that topologically unfolds the brain's electric pattern on a screen.

Fifty tiny electrodes are fastened to the patient's skull in five evenly spaced parallel rows. The first runs horizontally across the forehead; the last crosses the external occipital prominence.

Amplified impulses from the electrodes are translated into spots on an oscilloscope screen. The brightness of the spots is proportional to electrical potential, and spots on the screen follow the pattern of the electrodes, giving a two-dimensional, topological mosaic of the brain's electrical activity. A more precise quantitative measurement of the potentials is given by changes in the lengths of a series of illuminated columns, each corresponding to a spot.

Psychiatrists at the Institute for Advanced Training of Physicians in Moscow have now examined 659 patients with the "toposcope," according to Dr. A. V. Snezhnevsky, a member of the USSR Academy of Sciences. He was one of a group of top Russian scientists attending the recent "Pavlovian" conference on higher nervous activity at the New York Academy of Sciences.

In healthy individuals, bioelectric mosaics are dynamic, changing every 0.04 to 0.08 seconds, says Dr. Snezhnevsky. The mosaics are varied, seldom repeated. There are many changes of potential in different areas, sometimes compensated by simultaneous changes in other areas—as a rise in negative potential in the frontal lobe, balanced by a rise in positive potential in the occipital lobe.

In schizophrenic patients, however, the electroencephaloscopic pattern is markedly different, increasingly complex, with many local changes. Dr. Snezhnevsky subdivides the disease into four main stages, each more severe than the preceding:

Paranoid patients suffering from delusions but not hallucinations have inactive mosaics with infrequent waves of small intensity spreading from the forehead to the occiput. Inert foci of hyperactivity are not usual. When a light stimulus is applied, a change in mosaic is observed more often than with any other form of the disease.

Paranoiacs suffering from delusions and hallucinations produce even more inert mosaics. Changes in pattern are less frequent and the mosaic responds less often to light stimulus. Inert foci of excitation are frequent, sometimes creating a picture of asymmetry between the hemispheres.

Paraphrenics with delusions of persecution or grandeur complicated by dream-like hallucinations produce mosaics with stable foci of hyperactivity becoming sluggish with a wave duration as long as 1.5 seconds, or about twice as long as that observed in normals.

Secondary catatonics (non-reactive stuporous patients) exhibit still greater complexity and inertness in bioelectric mosaics. "Constellations," or periodic repetitions of the same distribution of cortical potentials, are observed.

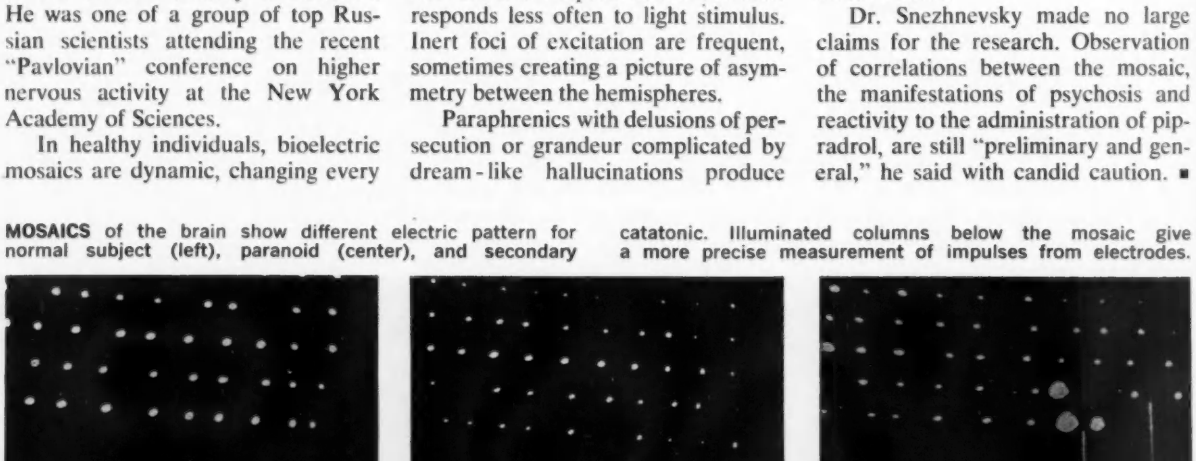
After the electronic diagnosis, the patients were tested with pipradrol (*Meratran,* Merrell), a central nervous system stimulant. Many patients responded with increasingly active mosaics, but most paraphrenics and catatonics did not.

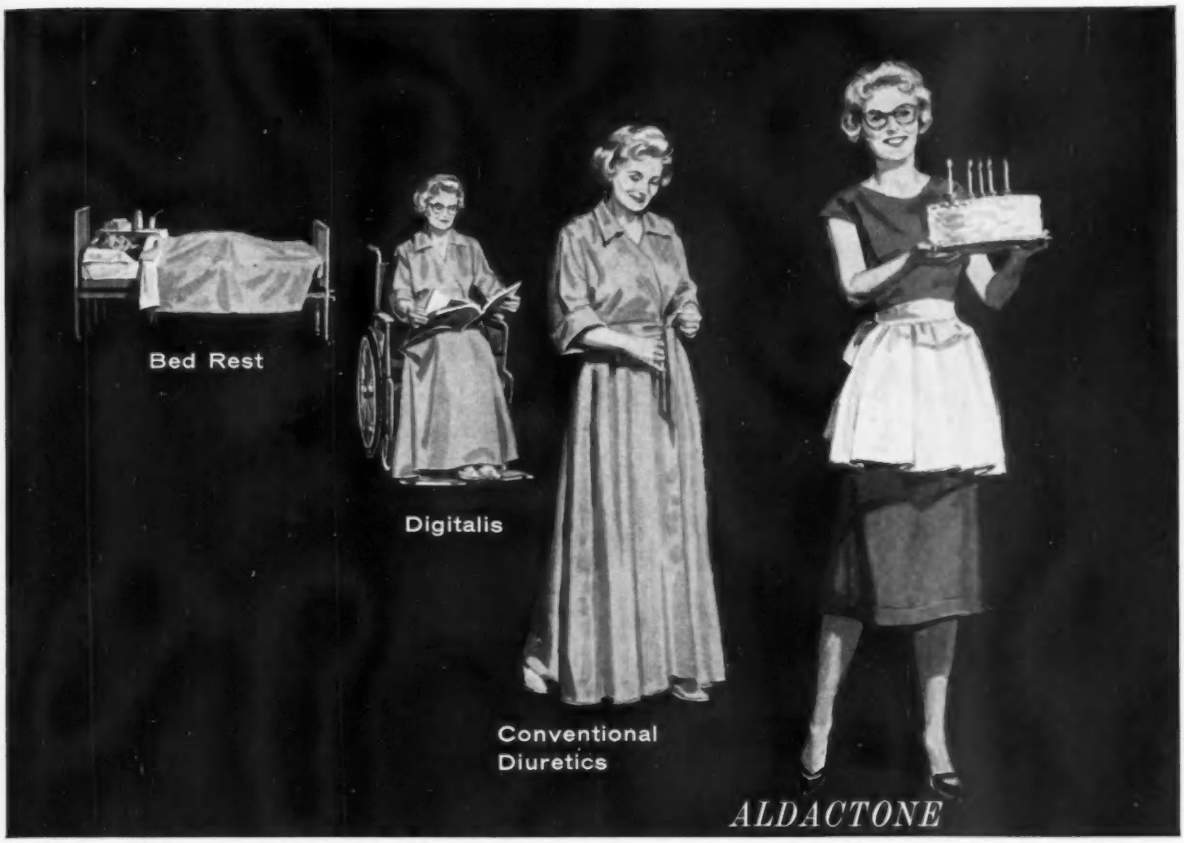
Those who responded to pipradrol tended to respond to chlorpromazine, with symptoms disappearing in the reverse order of their appearance. Paraphrenics and catatonics, however, showed little or no improvement under chlorpromazine therapy.

As schizophrenia develops, says Dr. Snezhnevsky, bioelectric mosaics are generally more complex. "It can be said, with many qualifications, that in the hallucinatory-paranoid state, foci of elevated activity arise more often in the area of the temporal lobe, and in the catatonic state, in the motor cortex."

Dr. Snezhnevsky made no large claims for the research. Observation of correlations between the mosaic, the manifestations of psychosis and reactivity to the administration of pipradrol, are still "preliminary and general," he said with candid caution. ■

MOSAICS of the brain show different electric pattern for normal subject (left), paranoid (center), and secondary catatonic. Illuminated columns below the mosaic give a more precise measurement of impulses from electrodes.





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ALDACTONE is a new classic step forward in the treatment of severe and resistant edema, achieving hitherto unmatched efficacy in relieving this condition.

A typical case history illustrates the extent to which Aldactone can supplement and advance established medical resources for treating edema and ascites.

Report of a Case*

Mrs. L. S., 44, was admitted to the hospital on April 17, 1959, with massive ascites, 3-plus edema of the legs and moderate pulmonary congestion. Three previous admissions had established that she had rheumatic heart disease with cardiac enlargement, atrial fibrillation and mixed valvular lesions.

She was placed on a regimen of bed rest, digitalis and 0.5 Gm. of sodium daily. On treatment which included mercurials parenterally, hydrochlorothiazide, KCl, NH_4Cl, aminophylline, prednisone, acetazoleamide and lysine monochloride the patient lost 15 pounds, but her ascites did not diminish noticeably and her weight remained within the range of 130 to 135 pounds from May 1 to May 30.

On May 30, 100 mg. of Aldactone q.i.d. was added to her regimen. Progressive and continuous diuresis followed. Weight dropped from 130 to 107 pounds, her normal weight. The patient was discharged on June 14 completely free from ascites and peripheral edema.

She was maintained on digitalis and hydrochlorothiazide and had no further weight gain until December 1959. She was then given 400 mg. of Aldactone daily for five days and again achieved dry weight, which was maintained as of February 1960.

SUPPLIED: Aldactone (brand of spironolactone) is supplied as compression-coated yellow tablets of 100 mg.

Klass, A.: Cur. Therap. Res. *2*:322 (July) 1960.

G. D. SEARLE & CO., Chicago 80, Illinois
Research in the Service of Medicine

ELECTROCARDIOGRAM TAKEN ON THE FLY

Micromanipulation reveals that the ordinary housefly may have a remarkable heart

The greenish screen of the oscilloscope in the basement of the biology building at Fordham University in New York showed a blurred wavering line. Sitting nearby on a high stool, an intent young man, his head buried in a two-foot high copper wire cage, glanced at the screen out of the corner of his eye, cautiously pulled his head back, gently closed the cage door and settled down to watch a unique electrocardiogram: that of a housefly.

The closed wire cage cut most of the outside electrical interference and the EKG was now running smoothly and regularly. The heart-beat settled at 230 per minute. The line on the oscilloscope showed a neat up-and-down stroke similar to that seen in a ventricular tachycardia tracing. In a wax-filled cup, under minute electrodes, was pinned a female Musca domestica about 6 mm long. It had been anesthetized with ether, its legs amputated, abdomen opened and flaps pinned down to the wax, stomach and kidney tubules (ventral in the fly) removed and the heart exposed. One of the electrodes rested on the tubular heart that runs along the first five segments of the fly's abdomen (there are nine segments altogether). Another wire was grounded on a nearby portion of the housefly's body.

Under the dissecting microscope (50X) the greyish heart, one to two mm long, visibly pulsates. Its shape resembles that of a Tootsie Roll.

D. Robert Brebbia, a graduate biology student whose doctorate research includes the fly's EKG, says little is known about the insect's heart. It is not known whether it is made up of compartments — though when the heart is sectioned, different regions beat at different rates. Nor is it known whether it works by wavelike or massive contraction, whether there are one or several pacemakers, nor whether the pacemakers are activated by nerve or muscle cells. (Survival of isolated sections, says Brebbia, suggest the existence of ganglia.)

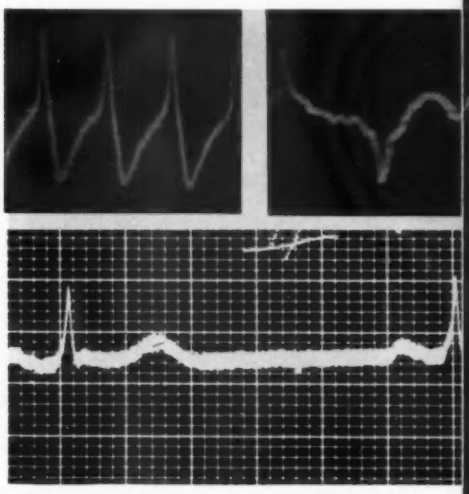
An Electrode May Be Slipping

The "normal" beat of the heart of the fly, he says shows fusion of wave components. When it is slowed down to less than 100 beats per minute by a cold saline solution, however, subwaves appear that look like some of the components of the human EKG, though Brebbia cautiously hesitates to make the comparison. It is possible, he says, that components may be traumatic artifacts or electrodes might be slipping.

Electrocardiographing the housefly is no mere stunt of micromanipulation. The main purpose of Brebbia's work was to assist Dr. Daniel Ludwig, head physiologist at the laboratory, in developing an "ideal" saline solution to maintain isolated organs of different species of insects for physiological studies.

Often working at night, when the use of heavy electric machinery does not disturb his sensitive amplification system, Brebbia has also studied the frog's heart and various electrical potentials in the cockroach. Working fast, with a steady hand, he can now set up a fly's EKG in five minutes flat.

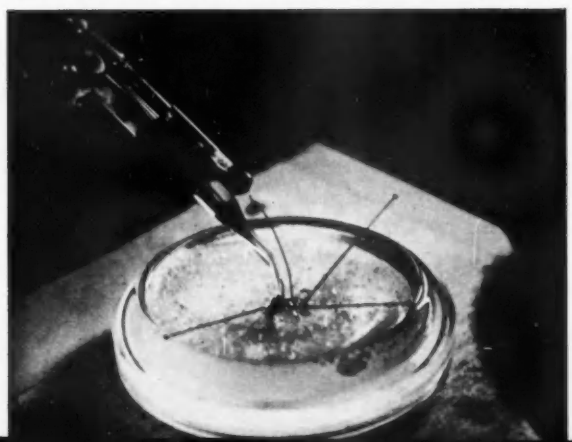
His work with the fly, he says, is by no means finished. Brebbia does not expect to uncover information that will be of direct use to cardiologists, nor does he plan to harass flies with swatters to see whether psychological stresses will cause heart disease or disturbances. But he will attempt, in the future, to stain and photograph the fly's heart, to trace the fly's blood flow (the fly seems to have two aortas) to measure impulses from single nerve cells on the heart and, more generally, to follow by microminiaturization techniques the infrequently explored path to neurophysiological knowledge of insect life. ■



FLY'S EKG (top left) is "normal." Component waves appear when heart slows down (right). Human EKG is shown below.

WIRE CAGE isolates fly from electrical background noise.

ELECTRODE rests on fly's heart, another one on its body.



tool of research

RATTAIL HEAT TECHNIC

Twenty rats, in groups of four, are used in this modification of the method described by Davies *et al.*[1] The pain stimulus is provided by a heated resistance wire placed near the rats' tails. Direct contact with the hot wire is prevented by a specially designed water-cooled tail rest. Observers record the time interval that animals take to respond (tail jerk) to the heat stimulus.

Untreated rats react within three to six seconds. Any prolongation of this reaction time in animals receiving test medication is an indication of analgesia.

The rattail heat technic is one of many tests used by Lilly scientists to study the analgesic properties of compounds such as Darvon®.

1. Davies, O. L., Raventos, J., and Walpole, A. L.: Brit. J. Pharmacol., 1:255, 1946.

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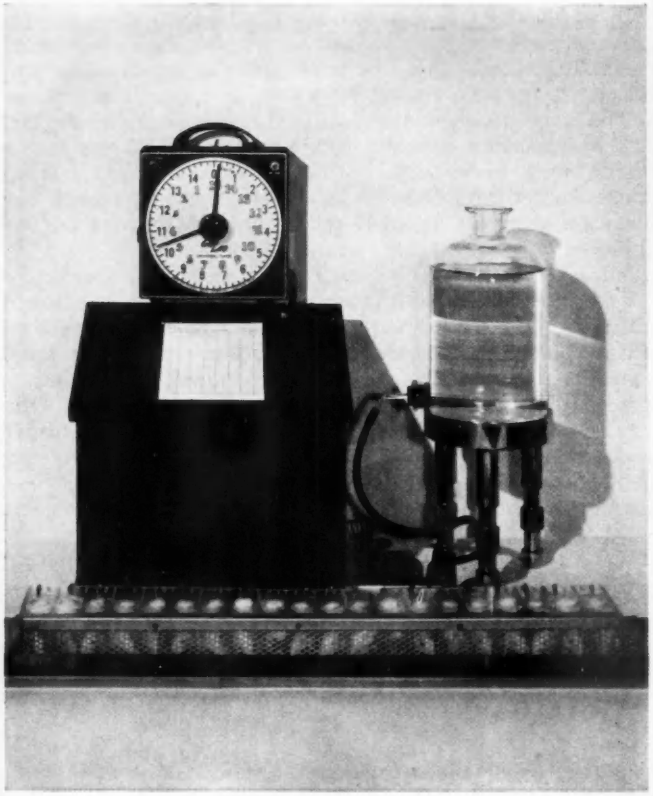

Rattail Heat Technic . . . valuable in preliminary screening of drugs for analgesic activity.

■ " . . . *the substitution of propoxyphene [Darvon] for codeine provides a distinct advantage.*"

Gruber, C. M., Jr.: J.A.M.A., 164:966, 1957.

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Darvon is safe . . . Contraindications to Darvon have not been observed. Darvon does not produce adverse changes in the peripheral blood, liver function, kidney function, or clinical progress. Even after prolonged therapy, Darvon . . .

- does not cause physical dependence
- does not produce euphoria
- does not lose analgesic activity

Usual Dosage: 32 mg. every four hours or 65 mg. every six hours.

Darvon is available in 32 and 65-mg. Pulvules®.

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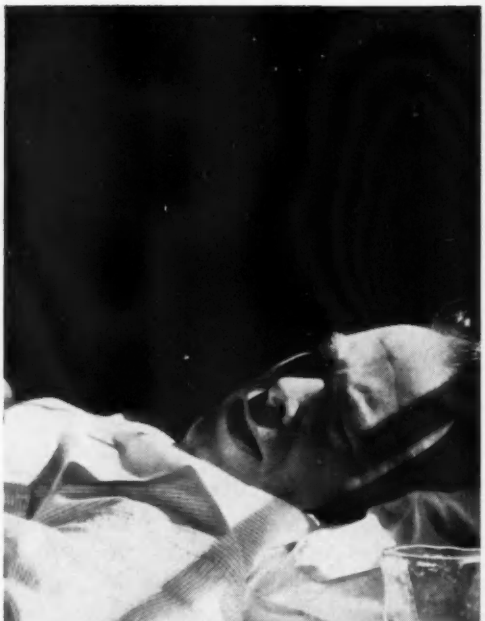
■ relief
from pain,
fever, and
inflammation



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Both products combine the analgesic advantages of Darvon with the antipyretic and anti-inflammatory benefits of A.S.A.® Compound. Darvon Compound-65 contains *twice* as much Darvon as regular Darvon Compound without increase in the salicylate content or size of the Pulvule.

Formulas:

Darvon Compound		Darvon Compound-65
32 mg.	Darvon	65 mg.
162 mg.	Acetophenetidin	162 mg.
227 mg.	A.S.A.®	227 mg.
32.4 mg.	Caffeine	32.4 mg.

Usual Dosage:

Darvon Compound: 1 or 2 Pulvules three or four times daily.

Darvon Compound-65: 1 Pulvule three or four times daily.

Darvon® Compound (dextro propoxyphene and acetylsalicylic acid compound, Lilly)
A.S.A.® Compound (acetylsalicylic acid, acetophenetidin, and caffeine, Lilly)
A.S.A.® (acetylsalicylic acid, Lilly)

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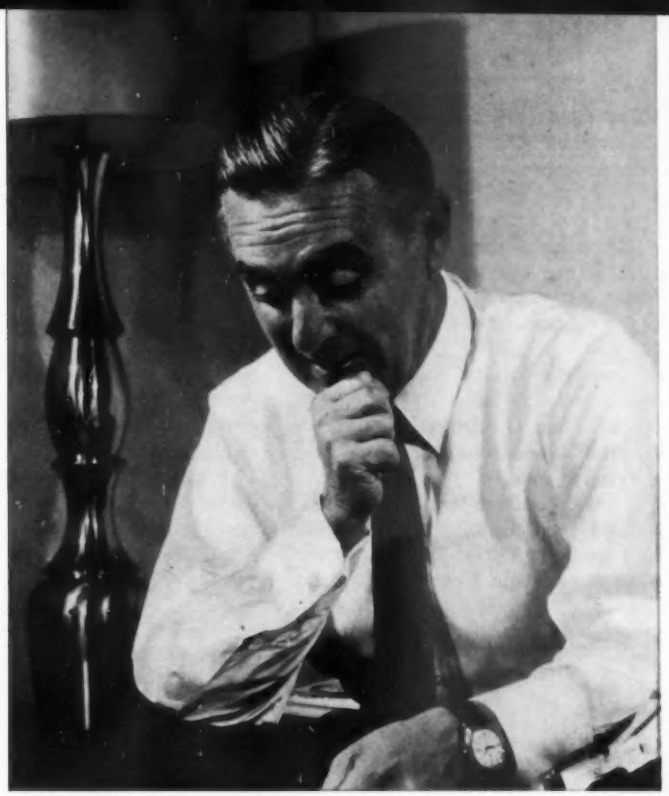
NEW HEALTH SECRETARY GOES TO WORK

Abraham Ribicoff is a moderate man who brings to the cabinet post a record of executive achievement and a knack for avoiding controversy



As the new Secretary of Health, Education and Welfare hurried down the corridor to one of many briefings on his new job, a reporter drew him aside.

"Are you personally committed to the Social Security approach to health care for the aged?" he asked.

Abraham Ribicoff turned: "I'm certain of *only* one thing. I will support the Kennedy program on aged care."

Actually, the soft-spoken former Governor of Connecticut will do more than support the program; he will be the field general in the Kennedy Administration's campaign to sell it to Congress and the nation.

The struggle will pit him against the AMA on the one hand and ally him with the AFL-CIO and Democratic liberals on the other. Yet his own philosophy lies somewhere in between. For like most of the other members of the Kennedy team, Ribicoff sees himself essentially as a political moderate who shies away from extremes in any area of policy.

"I'm no wild and woolly liberal. Such people have their place, but they always want to move too fast. If a system has worked all these years, there's nothing wrong with waiting a few more. You can't be in too much of a hurry and still get things done."

No one would deny that "Abe" Ribicoff *does* get things done. The son of poor immigrant parents, he worked his way through college and law school and went on to become one of the most successful political leaders in Connecticut history.

Despite Democratic affiliation, he won two terms in the Republican-dominated state legislature, two terms in Congress and finally an unprecedented two terms as Governor. He was the first Jewish governor in New England history and he won at a time when Republicans were carrying every other state office.

The Discreet Democrat

One of the secrets of his success —in addition to his shrewd mind and extraordinary energy—was his careful cultivation of a "middle-of-the-road" approach that not only satisfied most Democrats but appealed to Connecticut's Republican majority.

In keeping with this, he put great emphasis on "non-partisanship," submerging his party connections to the point that one writer was moved to call him "The Discreet Democrat."

The new HEW Secretary is also adept at avoiding controversies. "You will never find a public statement by me criticizing anybody," he says. "In 1954, I ran a campaign without ever once mentioning my opponent's name. I run a campaign on what I'm for, not what I'm against."

In the health field, Ribicoff has long avoided getting into squabbles with the medical profession. One notable example was a major controversy that developed over reorganization of Connecticut's Blue Shield programs. Ribicoff might have been tempted, like some other governors, to have his insurance commissioner barge in to force a settlement. But he maintained a strict hands-off policy.

More recently, the Connecticut Welfare Department collided with the state medical society over the use of generic names in prescriptions. The governor purposely kept completely out of the line of fire and took no sides.

During his six years in the executive mansion, Ribicoff presided over a major expansion of the state's health programs. Direct spending for mental health climbed from $27.9 to $45.2 million, and bond issues raised another $20 million for mental institution construction. Connecticut also spent more per capita on aged medical care than any other state.

The medical care program—which

CONTINUED

Ribicoff called "one of the nation's most comprehensive"—was tied in with Public Assistance and, on the whole, was acceptable to physicians.

Through all this activity, the Governor enjoyed good relations with the medical profession. As one state society official reported to MEDICAL WORLD NEWS: "I've done quite a bit of traveling around the state and I didn't find any animosity among the doctors. The Governor was quite an expert at avoiding unnecessary or useless controversy."

Ribicoff did deliberately cross lines with physicians at one point, however. Last year, he joined 13 other governors in notifying Congress that they supported the Social Security approach to Federal medical care for the aged. By this time, however, he was already deeply involved in Kennedy's move toward the presidency.

Close Friends and Teammates

Ribicoff's fruitful link with President Kennedy dates back to 1949 when they first served together in the House. They quickly developed a warm friendship and a mutual respect. On many issues—particularly in the field of foreign affairs and in matters concerning New England—they worked closely and effectively.

Years later, at the 1956 Democratic convention in Chicago, the relationship took on national dimensions. Kennedy was fighting for the vice-presidential nomination on the ticket with Adlai Stevenson. Ribicoff made the nominating speech and helped lead the campaign.

The two lost their battle, but they continued as close friends and political teammates. And as the Massachusetts Senator began developing his extraordinary political machine for the drive toward the White House, Ribicoff remained one of Kennedy's top lieutenants.

During the presidential primaries last year, Ribicoff campaigned hard and long. Behind the scenes, he also played an important role in mapping the victory strategy. At the Democratic convention in Chicago, he was Kennedy's floor manager. During the campaign, he stumped, hustled, talked and maneuvered in every section of the country. He also delivered Connecticut votes by a 92,000 majority.

It was understandable then that Ribicoff was almost the first man consulted when the President began lining up men he wanted for his Administration team.

Ribicoff's intimate, first-name basis with Kennedy will be one of his great strengths in the HEW post, where he will be the storm center of controversy over aid to education and medical care for the aged. None of the previous HEW secretaries enjoyed the same kind of relationship with the President.

On this friendly level, Ribicoff, a very skilled politician and administrator, will always have full access to the White House to plead his particular causes. Because of his years in Congress, as well as service in the Democratic election drive, he will also have far more political influence in Congress than his predecessors.

If his record is any clue, Ribicoff can be counted on to speak his mind to both the President and Congress, for he prides himself on his independence. A typical example of this occurred during his tour as a freshman congressman. Influential constituents asked him to introduce and back a bill to put shade-grown tobacco under price supports. He introduced the measure for them but then announced publicly: "I want it understood I oppose this bill."

Succumbing to Politics

Ribicoff, a handsome man with only traces of gray hair, looks younger than his 50 years. He is married, with two children.

He was born in New Britain, Conn., attended New York University and got his law degree from the University of Chicago in 1933. He practiced law in Hartford, but soon succumbed to politics, going to the state assembly in 1939. He served later as a police judge and entered Congress in 1949. He won the Governor's chair in 1954 and later a second term by an unprecedented majority.

Little in the new Secretary's record suggests any special interest in the health field. He reports he has never even taken a public stand on Connecticut's controversial birth control law. And he shies away from expressing himself on specific Federal issues before he has been fully briefed, limiting himself to voicing support for the Kennedy plan on medical care for the aged and indicating that something has to be done about construction aid for medical schools.

But Abraham Ribicoff is a brilliant administrator, with a tough, resourceful mind. He is a hard driver and, at the same time, a skillful negotiator and compromiser. He has strong personal support and the confidence of the President. He knows politics and Congress. He likes the middle road, but will back the Kennedy program all the way. ■

PRESIDENT-ELECT Kennedy makes Connecticut governor first choice for the cabinet.

PRACTICING MD BECOMES NEW SURGEON GENERAL

Dr. Luther L. Terry, the new Surgeon General of the U. S. Public Health Service, is more than a veteran Government researcher and administrator. He is a superb clinician who was still making his ward rounds until the time of his appointment.

"The thing he'll miss most in his new job will be the contact with patients," said a National Heart Institute colleague. "I'll bet he'll still drop out here every once in a while to check up on how we're handling our cases."

It is unusual for an active physician, even if he was assistant director of the Heart Institute, to be tapped for the top health service post. In most cases, the assignment goes to an administrator long removed from hospital ward or laboratory. But Dr. Terry had the powerful support of his longtime patient and friend, Sen. Lister Hill (D-Ala.). He also had the backing of influential New York medical research leaders and many members of the Commissioned Officers Association, which he heads.

DR. LUTHER L. TERRY is popular choice.

The 49-year-old new Surgeon General grew up in the little town of Red Level, Ala. His physician-father, Dr. James E. Terry, was a close friend of Sen. Hill's father, also a doctor, so that the two boys knew each other long before their paths crossed again in Washington.

Dr. Terry obtained his medical degree at Tulane in 1935 and subsequently taught at Washington University, St. Louis, and the University of Texas. In 1942, he joined the Public Health Service Hospital where he served for ten years, mostly as chief of medical service. At the same time, he taught at Johns Hopkins.

Even before he left the PHS Hospital, Dr. Terry took charge of the general medicine and experimental therapeutics branch of the young Heart Institute. And in 1953, he moved over to the Institute on a permanent basis, becoming assistant director five years later.

As a researcher, his primary interest has centered on the mechanisms of hypertension. He and his group helped pioneer the effort to combat the disease by interferring with the biochemical intermediates of vasodilation and constriction. One of the most promising lines of research was the so-called monoamine oxidase inhibitors, which counteract the enzymes that normally destroy amines affecting blood pressure.

Dr. Terry's long service as a practicing clinician, his intimate knowledge of hospital problems, and his close ties with academic medicine all combine to make him a popular choice among the commissioned PHS corps and the medical community as a whole.

New Legislative Assistant

Wilbur J. Cohen of the University of Michigan, named as Assistant Secretary of HEW for Legislation, is a perennial antagonist of the AMA. He will mastermind strategy for winning Congressional approval of a Social Security-type aged care program.

Cohen was a longtime official in the Social Security Administration, serving as technical adviser or research specialist during the 30's and as research director under Health Secretary Marion B. Folsom.

After the war he led in the campaign to pass the Murray-Wagner-Dingel bill. And last year he played a key role in drafting the Forand-style aged bill championed by President Kennedy and the Democrats. He also headed the Kennedy Health and Social Security task force (see p. 42) which has just called for a $1 billion Social Security-based aged care plan. ■

WHO SETS U. S. RESEARCH POLICY?

Government officials and politicians get the headlines but the real movers and shapers of medical spending and research planning are a select group of private citizens

To insiders in Washington, the appointment of Boisfeuillet Jones of Emory University as top medical affairs adviser to the new health secretary came as no surprise. He was a natural choice.

Mr. Jones is not a physician. He is not even particularly well-known to the rank and file of the medical profession. But he is no stranger to men who preside over the Government's vast operations in the health field.

He is, in fact, one of a small band of men and women outside the Government who exert an enormous behind-the-scenes influence on both the size and form of Federal investments in such multi-million-dollar programs as medical research support.

Others of this select group include: Mrs. Albert D. Lasker, New York philanthropist; Dr. Sidney Farber, Boston pathologist; New York banker James A. Adams; Dr. Michael E. De Bakey, Houston surgeon; Dr. E. Cowles Andrus, Baltimore cardiologist; Dr. Isidor S. Ravdin, Philadelphia surgeon; and Dr. Howard A. Rusk, New York rehabilitation authority. The common ingredient of these eight: great energy, dedication and, above all, extraordinary influence on the centers of Federal power.

They Hold the Reins

In Washington, the ultimate power is invariably political. In medical research this power can be traced directly to Sen. Lister Hill (D-Ala.), Rep. John E. Fogarty (D-R.I.) and the administration in office. Together, these three hold almost unchallenged sway over what is spent and what is done by the Government in this field.

The research arm of the Government, the National Institutes of Health, uses about 1,000 private physicians, scientists and laymen in nine national advisory councils, 35 study sections and dozens of other standing and ad hoc committees.

NIH officials, together with these advisers, make most of the technical decisions on the content of the national medical research effort. But on the twin crucial issues of how much money is to be spent and the way it's to be spent—the collaborative vs the individual approach, for example—they are far less influential than the eight who have played a major role in spurring the NIH budget from a mere $3.4 million in 1946 to a record $560 million this year. They also have helped set U. S. research emphasis on cancer, heart disease and mental health. And they have sparked huge collaborative projects like the $28 million cancer chemotherapy program.

"Bo" Jones is a notable case in point. President Kennedy referred to Jones—who is director of Emory's medical programs and a member of NIH's National Advisory Health Council—as a "nationally renowned figure in the field of health and medicine." Perhaps more significant is the fact that he has long been a close personal adviser to Sen. Hill.

Blue Ribbon Committee

An illustration of his position came in 1959 when the Hill Health Appropriations Subcommittee demanded an independent investigation into how much money NIH could spend efficiently. The Senator turned to the Emory vice-president to head a special blue-ribbon investigating committee which also included Drs. De Bakey and Farber.

The Jones Committee, as it later came to be known, called for an immediate $264 million jump in NIH's budget—from $400 to $664 million—and suggested that the Federal share of the national research should reach $2 billion by 1970. On the strength of this recommendation, the Senate voted the $664 million—which was only partly cut back by an enforced compromise with the House.

Another classic illustration of the effectiveness of the eight involves the massive cancer chemotheraphy program which, since it was launched seven years ago, has been the target of both bouquets and brickbats.

In the beginning, NIH officials suggested to Sen. Hill a modest collaborative program—about $500,000—to investigate potential agents for acute leukemia. NIH felt strongly against inaugurating a large-scale program until improved techniques and basic discoveries were available.

But Dr. Farber, head of the chemotherapy program's first advisory committee, strongly favored the all-out approach and with the help of Mrs. Lasker, Dr. Ravdin and others, he won his way.

Appropriations Soar

Congress immediately doubled the suggested budget to $1 million and then poured on increases as the screening effort got underway. Appropriations climbed to $5 million in 1955, to $19 million in 1956 and to the present level of $23 million a year.

The multi-million-dollar psychopharmacology program has a similar history. It, too, had formidable opponents but they were no match for the impressive support lined up in this case by Mrs. Lasker. She and her colleagues effectively showed Messrs. Hill and Fogarty that a large-scale collaborative effort would speed the discovery of better psychic drugs.

The non-Governmental advisers do not always succeed overwhelmingly in their efforts. In 1959, for example, Drs. Rusk, Farber and Ravdin helped lead the fight for a $50 million international medical research program. In the face of determined opposition in the House and a number of objections by the Eisenhower Administration, the proposal was greatly altered and watered down.

But with their zeal and influence it's most unlikely that members of the eight who feel strongly about the program are going to let the alterations in the legislation slow them down. With "Bo" Jones now officially in a policy-making position, and with what they feel to be a favorable climate elsewhere in the Administration, they are already starting to work to create the fullest possible program—and to find ways of restoring the needed financial backing. If an international research project eventually becomes a major feature of U.S. medical affairs, there will be no doubt where credit is due. ■

CLOSEUP OF EIGHT LEADERS

Boisfeuillet Jones

Longtime confidant and adviser of Sen. Lister Hill, Jones is noted for solid judgment, unemotional analysis of the facts and persuasive leadership behind the scenes among research leaders. Always guaranteed a careful hearing by Government medical officials he is much sought after for advice and help in influencing programs and ideas.

Jones was vice-president and administrator of health services at Emory University in Georgia until his appointment as Special Medical Affairs Advisor to the HEW Secretary. He is also a member of the National Advisory Health Council and the American Academy of Political and Social Sciences.

A native of Macon, Ga., Jones received both his bachelor and law degrees from Emory, became state administrator and later was regional chief for the National Youth Administration until 1943. He taught political affairs at Emory after the war, became legal consultant to the Commission on Human Medicine of the Southern Regional Education Board, and headed a blue ribbon panel which surveyed American medical research for Sen. Hill in 1959.

Mrs. Albert D. Lasker

Mrs. Lasker combines single-minded dedication to medicine with extraordinary intelligence and a zeal for hard work. With many friends among the leaders of American business, she can enlist strong backing in almost any area. Known and respected by everyone in the health field, she also has the ear of men like Senator Hill (D-Ala.) and Rep. John E. Fogarty (D-R.I.), and is listened to by Government leaders.

With her late husband, she established the Albert and Mary Lasker Foundation which specializes in medical research and public health education. She is its president. A prime mover in swinging Government medical research from the old post-war National Science Foundation to National Institutes of Health, she is a member of the National Advisory Heart Council and the National Advisory Cancer Council.

Mrs. Lasker is also chairman of the National Health Education Committee, co-chairman of the National Committee Against Mental Illness, honorary chairman and board member of the American Cancer Society, honorary vice-president of the Planned Parenthood Federation of America.

Dr. Michael E. De Bakey

Despite a heavy clinical load, Dr. De Bakey devotes a great deal of energy and time to Federal medical research planning. A veteran of the ins and outs of Federal Government, he has both high professional standing and many powerful political connections.

He is chairman of the department of surgery at Baylor University College of Medicine, Houston, and a member of the National Advisory Heart Council. During World War II, he headed the Surgical Consultants Division of the Army Surgeon General's office, and played an important role in the wartime National Research Council, a forerunner of large-scale postwar support for medical research. He is still a member of the Council's executive committee.

Former co-chairman of NRC's Medicine and Surgery Committee and a member of the Medical Service Committee of the Hoover Commission, he has become a friend of such political powers as Vice-President Johnson and Sen. Hill. Dr. De Bakey helped write the health plank in the Democratic platform; previously he had performed a similar task for ex-President Eisenhower's Commission on National Goals.

CONTINUED

Dr. Isidor S. Ravdin

One of the senior philosophers of U.S. surgery, Dr. Ravdin is influential within the profession as well as with Government and congressional leaders. He teams with Dr. Farber to testify annually before Congress on major cancer programs and grants.

He is vice-president for medical affairs at the University of Pennsylvania, a member of the National Advisory Health Council, former member of the National Advisory Cancer Council and president of the Board of Regents of the American College of Surgeons.

With Dr. De Bakey he got in on the ground floor of Government research support problems with the National Research Council during World War II, later supported the idea of pushing medical research mainly through NIH rather than the Council or the National Science Foundation.

James S. Adams

A wealthy New York investment banker and director of Carter Products, Inc., Adams has important connections among U.S. industrial leaders. Determinedly dedicated to the cause of medicine and medical research, he is very effective in quietly lining up support for causes that attract his attention, such as the postwar organization of the nation's research effort.

With the Laskers and others he also reorganized the American Cancer Society in 1944, held offices in ACS from 1945 through 1955. Currently, he is an honorary life director of the Society and chairman of its legislative committee.

Again with the Laskers and others, he helped spur phenomenal increases in Government spending for cancer research. He helped establish the National Heart Institute, National Institute for Mental Health, Institute of Neurological Diseases and Blindness, and other research organizations, took the lead in a fight for Federal aid for construction of medical research facilities, and was one of the behind-the-scenes backers of the plan for an Institute of International Medical Research.

Dr. Sidney Farber

As scientific director of the Children's Cancer Research Foundation in Boston, which gives him a strong professional base for exerting leadership, Dr. Farber works hard, spends a lot of time advising on Government research programs. He has an unusual ability to present facts persuasively and stir enthusiasm for causes he is interested in.

A professor of pathology at Harvard, he is also a member of the National Advisory Health Council and former member of the National Advisory Cancer Council. Dr. Farber helped spark the launching of the big national chemotherapy program, still heads the Cancer Chemotherapy National Committee and the chemotherapy committee of the Advisory Cancer Council.

His discovery that folic acid antagonists can produce marked improvement in children with acute leukemia was a major research contribution—one which helped focus attention on the chemotherapeutic approach. Dr. Farber is a life honorary chairman of the United Cerebral Palsy Association's Research Advisory Board, first chairman of the Research Advisory Board of the Cystic Fibrosis Association, and adviser to the Muscular Dystrophy Association.

Dr. E. Cowles Andrus

With a superb ability to interpret science to laymen, Dr. Andrus also can be very persuasive among major supporters of research and win backing for programs. He knows the Government thoroughly, speaks from an authoritative position at Johns Hopkins Medical School.

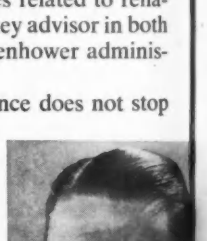
A professor of medicine and chief of cardiovascular diseases, department of medicine, at Johns Hopkins, he is now in his second term on the National Advisory Heart Council, has served as a special consultant to the Surgeon General, as chairman of the National Heart Institute's cardiovascular study section, as senior scientific consultant to the Institute, and as a president of the American Heart Association.

During World War II, he served as assistant to the chairman of the Medical Research Committee of the Office of Research and Development. Now he spends considerable time on research organization and support problems.

Dr. Howard Rusk

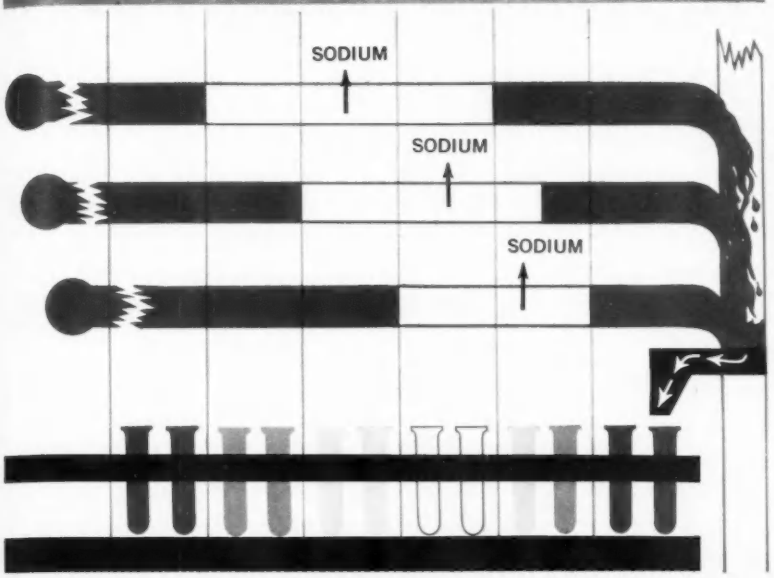
A veteran in the Washington merry-go-round, Dr. Rusk almost single-handedly made the Office of Vocational Rehabilitation into a large-scale operation. He pioneered the AAF Convalescent-Rehabilitation Training Program during World War II and has since strongly influenced all governmental policies related to rehabilitation. He was a key advisor in both the Truman and Eisenhower administrations.

Dr. Rusk's influence does not stop at U.S. boundaries. His knowledge of world medicine, gained from studies of rehabilitation services in 37 countries, has won him influence in a dozen international medical bodies. He was one of the initiating powers behind the International Health Bill.



A man of inestimable energy, he is among other things, professor and chairman, department of physical medicine and rehabilitation, New York University-Bellevue Medical Center and an associate editor, *The New York Times*.

It has been estimated that he serves as consultant or member of committees of more important medical groups than any other man.



PATTERN of sodium concentration in test tubes (color shading), produced by pooled output from nephrons of different lengths, locates areas of sodium resorption.

STOP-FLOW ANALYSIS MAPS NEPHRON FUNCTION

Secretion and absorption along tubule can be pinpointed by 'backing up' a column of urine

Current theories of nephron function owe a large debt to pharmacologist A. N. Richards who, in 1924, devised a method of puncturing the nephron with fine capillary tubes to draw off urine for analysis.

Unfortunately, this method was poorly adapted to the mammalian kidney where the nephrons are deeply buried rather than on the surface, as in Richards' subject, the frog.

A more suitable procedure which does not require "tapping" into the nephron has now been developed at the University of Michigan. Called "stop-flow analysis," it is already being used to map the tubule sites that secrete or absorb substances such as sodium, potassium and water—a task that may help clarify understanding of electrolyte disturbance in congestive heart failure and other diseases.

In stop-flow analysis, the nephron flow is backed up by blocking the kidney ureter for a few minutes. The backed-up column of urine, subjected to a relatively prolonged period of secretion and reabsorption, develops exaggerated patterns of concentration along its length. These patterns can be plotted by releasing the ureter block and catching the urine in a series of small vessels for analysis.

In the hands of its inventor, physiologist Walter S. Wilde, stop-flow analysis has already revealed a good deal about nephron function in dogs and—inferentially—in human beings. Wilde and his associates have charted the absorption and secretion of sodium, glucose, phosphate and potassium throughout the entire length of the nephron, particularly the distal end.

The Michigan team has been devoting particular attention to the effects of drugs on sodium and water retention, which play a key role in a variety of pathological conditions.

Aldosterone, the adrenal steroid regulating sodium retention, acts on the nephron's distal segment, they find. Tracer experiments with radioactive sodium indicate that the hormone increases salt retention—and, therefore, water retention—by stepping up the efficiency of sodium reabsorption.

Oubain, a cardiotonic and diuretic akin to digitalis, also acts on the distal segment, but in an opposite manner: it steps up sodium excretion by cutting down its reabsorption. The chlorothiazides and mercurials, on the other hand, reduce the reabsorption of both sodium and water, and act on the proximal rather than the distal end. ■

ESTROGEN AND A PRINCE OF SIAM

KWAO vine twines about jungle tree.

An odd bit of Oriental folklore leads to a Hollywood-type hunt for an alleged elixir of youth

The romance of drug-hunting has survived the prosaic reign of white-coated men in sterile laboratories. Exotic pharmacology, which found curare in a South American arrow poison and reserpine in an Indian love potion, can still unfold a fabulous tale. A case in point is its latest scientific scenario, complete with an elixir of youth, an Oriental prince and an ancient manuscript found in a ruined temple.

The story begins with a 1932 report by an Englishman in Siam (now Thailand) that elderly natives got a new lease on life by eating the root of the kwao vine, a jungle creeper of the bean family. Thai and German investigators soon found the source of the plant's "rejuvenating" effect: its tubers contain a strong estrogen. But the war buried their reports.

In 1948, British and Australian workers, studying plant-produced estrogens, dug out the earlier references. Their curiosity aroused, they embarked on a full-scale investigation of kwao, which Dr. James C. Cain, of the National Research Development Corporation, London, has now reported in *Nature*.

An expedition to Thailand, aided by Prince Lakshnakara Kashemsanta, one of the botanists who had studied the plant, secured several hundred pounds of the root. It also turned up a pot of kwao "medicine"—a mixture of dried roots and honey—and a pamphlet in the Thai language describing its interesting properties.

Written in 1931 by a Thai civil servant, the pamphlet was based on an ancient Burmese medical treatise inscribed on palm leaves, which had been found in a temple wrecked by lightning. Kwao, it declared, was well known in both Thailand and Burma, and was reputed to make old people young. One patient was said to have reached the age of 280. Young persons should eschew kwao, the pamphlet noted—without explanation.

Back in the Lab

Meanwhile, back in London, a research team was purifying the active principle of the roots. Biological tests of the compound, christened mirestrol, showed an estrogenic potency comparable to diethylstilbestrol and estradiol; oral and subcutaneous administration seemed equally effective. Clinical trials by Dr. P. M. F. Bishop, at Chelsea Hospital for Women, indicated an efficacy comparable to other oral estrogens in cases of amenorrhea and artificial menopause.

But elixirs of youth—as Faust discovered—generally have a catch. Mirestrol also produces side effects: malaise, headache and nausea, which appear to make it "unsuitable for use in medicine." Studies of its chemical structure also proved disillusioning. Its steroid-like molecule, somewhat resembling estradiol, "does not display as great a novelty in regard to its structure-action relationship as was first thought possible."

Concealing his disappointment with true British *sang-froid*, Dr. Cain observes that mirestrol "nevertheless presents some features of interest. Further investigations of its biological properties are proceeding." ■

CITIZENS' session hears the results of internal wrangle over Federal health care.

AMA LEADERS SET BACK AT CONFERENCE ON AGING

Backers of Social Security financing for care of the elderly win power struggle in White House meeting

The White House Conference on Aging was a distinct disappointment to the leaders of the AMA. Practically everything went wrong. And by the time the last participant left Washington, it was clear that the experience had cost the AMA more than it had gained.

In the beginning, the AMA was charged with "rigging" the conference committees in order to block support for a Social Security-style aged care program. But events quicky revealed that the principal accusers — the smooth-working labor delegates — were actually in control.

The AMA also thought it had reason to expect the support of Republican leaders.

Yet it got one of its sharpest setbacks when two officials of the Eisenhower Administration—former Health Secretary Marion B. Folsom and Labor Undersecretary Arthur Larson—threw in their lot with the Social Security forces.

Dr. Leonard W. Larson, AMA president-elect, won the backing of his health and medical care section for an attack on the Social Security approach. But the income maintenance section which was charged with the financing problem rolled through a resolution giving the Social Security approach a thumping endorsement. It declared that public assistance and voluntary insurance "will continue to fall short of meeting the basic medical care needs of the aged as a whole."

The end result was that the general public, and more particularly Congress, got the impression that the Conference leaned toward the Social Security formula. And this couldn't help but boost the chances of the AMA-opposed bill which the Kennedy Administration will push in the new Congress.

Genuine Citizens' Conference

(An inkling of the form that this bill may take was provided during the Conference when a Kennedy task force released a report calling for a $1 billion Social Security program covering health needs, see page 42).

The White House Conference was launched more than two years ago when Rep. John E. Fogarty (D-R.I.) introduced the appropriate legislation and the Democratic 85th Congress gave its approval. A Republican, Health Secretary Arthur S. Fleming, picked the leaders and set the guidelines on the national level. But state governors, mostly Democrats, appointed the individual delegates; two out of three were to be "non-professionals" to assure a genuine citizens' conference.

During months of planning on the state level, both organized medicine and labor sought to put their men on the key committees and win delegate support for their positions. It was a rough-and-tumble, behind-the-scenes struggle and, inevitably, the charges began to fly even before the national parley got underway.

Dr. Wilbur J. Cohen of the University of Michigan, chairman of the Kennedy task force and longtime champion of Social Security expansion, provided the initial spark by stating that the meeting had been "captured" by the AMA, private insurance men and business interests.

Dr. E. Vincent Askey, AMA president, lashed back, accusing Cohen of trying to "distort the truth and engage in reckless smears in an effort to mislead the people." In the crucial income maintenance section, Dr. Askey said, the work-group leaders included 25 representatives of labor and social welfare, only 14 representatives of the public, industry, and private insurance, and "only one —I repeat one—physician."

AFL-CIO president George Meany added more fuel to the fires by declaring that the AMA was less interested in health insurance than organized labor and gave the problem of the aged only "negative and hostile criticism" until other groups began to act.

Dr. J. Lafe Ludwig, chairman of the AMA's council on medical service, answered Meany by charging him with engaging in a "reckless cam-

AMA's Larson, loser in a rules dispute.

paign of rule-or-ruin and the public be damned." He said the "smear and hostility" tactics could wreck the Conference.

In this atmosphere, hundreds of other issues up for discussion were almost lost in the power struggle.

The first jolt to AMA hopes came the first afternoon of the conference while there was still some uncertainty over how the sections would vote—particularly the section on income and maintenance, headed by former Social Security commissioner Charles I. Schottland. Marion Folsom, with his former position in the Eisenhower Administration lending special weight to his words, spoke out for the Social Security formula.

Although the former HEW Secretary was one of the original advisers in the Social Security program and was known to be partial to the system, he carefully avoided pressing this approach to the health care of the aged while he was Secretary. He had emphasized government reinsurance to encourage broader private insurance coverage for the elderly.

But at the aging meeting he came out for the first time in favor of the Social Security approach. "The logical plan, and one which is endorsed by most students of the subject," he declared, "is to finance and administer a program of health insurance for retired people through the OASDI program."

The words of Folsom, a Republican, long-time leader in the aged care field, and conservative businessman, greatly impressed the delegates. And his views were reinforced later the same day by those of Arthur Larson, the so-called Republican Party philosopher.

Behind the scenes, AMA leaders huddled on strategy. Some delegates obviously had been swayed by Folsom and Larson. Labor representatives were lobbying effectively for the Social Security approach in nearly all of the Conference's 20 sections and dozens of work groups. AMA assistant executive vice-president, Dr. Ernest B. Howard, and the AMA's special troubleshooter on aging, Debs Meyer, argued strenuously that organized medicine had to counterattack hard in the health and medical care section where it was relatively strong.

AMA president-elect Leonard Larson held back, pointing out that the rules barred his group from making any recommendations in the financing field. Finally, he yielded.

Overruled on the Rules

By a vote of 165 to 122, Dr. Larson's section asserted that "existing Federal-state matching programs will provide effective, economical, dignified medical care for our elderly who need help.

"Compulsory health care inevitably results," the resolution added, "in poor-quality health care. We therefore feel that health care under the Social Security mechanism is unnecessary and undesirable."

Chairman Robert W. Kean, former New Jersey Republican congressman who was chairman of the Conference, ruled that it was a violation of the Conference rules for the Larson group to stray away from its main responsibility—recommending ways to improve health care. He met quickly with Charles Schottland and Dr. Larson to iron things out.

The result was a compromise in which the health and medical care section deleted the attack on the Social Security mechanism but retained the comment that "compulsory health care inevitably results in poor care"—an oblique criticism of the Social Security approach. In a separate report, presented by Dr. Lorin E. Kerr of the United Mine Workers, the minority rejected the majority claim that the quality of care would be "influenced by the source of payment."

Meanwhile, Schottland's income maintenance section tackled the financing question head-on under the

CONTINUED

reads report as Dr. Howard Rusk listens.

SECTION LEADERS Charles Schottland, Dwight Sargent and G. W. Hobbs hold debate.

AGING CONFERENCE CONTINUED

protection of the rules. By a vote of 170 to 99, it called for expansion of voluntary health insurance for the aged and broader coverage by insurance companies which could "contribute much to the solution of the problem.

"However," the resolution continued, these moves "will continue to fall short of meeting the basic medical care needs of the aged as a whole. The majority of the delegates of Section 2 believe that the Social Security mechanism should be the basic means of financing health care for the aged."

Because of the effective lobbying by the Social Security forces, several other sections detoured from their assigned fields to endorse the Social Security approach. But their action was ruled out of order, as was a move to have a mass vote by all 2,700 delegates.

Despite the fuss and furor on the financing of health care, the Conference did manage to address itself to some of the other pressing problems of the aged. In a series of recommendations, various sections urged:

- Creation of a Federal aging coordinating agency and a central national voluntary coordinating body as well as formation of local and state committees on aging.
- Establishment of a National Institute of Gerontology at the National Institutes of Health.
- Adjustment of old age benefits to changes in prices and wages, and action to provide better housing for the aged.
- Development of a voluntary accreditation program to assure better standards for nursing homes and similar institutions.
- Improved health maintenance education, better leadership by physicians, strong controls over advertising and labeling of products for the aged.
- More community preventive programs, added emphasis on home care to reduce hospitalization and broadened voluntary insurance coverage. ■

TASK FORCE MAPS HEALTH AND WELFARE PLANS

A Kennedy task force has called for a $1 billion aged care program tied to Social Security, massive Federal aid for medical schools and more medical care facilities to assure "an adequate standard of health and welfare for all of the American people."

The special study group, assigned to map urgent needs for Federal action in the health and welfare field, was headed by Dr. Wilbur J. Cohen of the University of Michigan, a longtime advocate of expanded Social Security benefits.

It also included Drs. Dean A. Clark of Massachusetts General Hospital, Boston; James Dixon, president of Antioch College; Robert E. Cooke, Johns Hopkins pediatrician; and Joshua Lederberg, Stanford University geneticist.

Key proposals in the report:

Aged Care—A Social Security-based program should be adopted, providing inpatient hospital services, outpatient hospital diagnostic services, skilled nursing home services and home health services.

The plan should be paid by a Social Security tax of about 0.5 per cent of taxable payrolls during the first five to ten years, then stepped up to about 0.8 per cent.

Free choice of physician, hospital and nursing home must be assured by law. Supervision and control over medical practice will be barred. Providers of service will be paid "on the basis of reasonable cost."

Most of the aged not covered by Social Security should be protected through the Veterans Administration and similar programs. "The small remaining group can be taken care of by the states under the new program of medical assistance."

Medical Education, Manpower—A large-scale program costing about $270 million a year should be launched "to increase the supply of medical and other health personnel."

Federal support would cover "operating costs" to maintain educational activities in the medical and health fields and to spur expansion of training for health jobs.

Aid for construction of new educational facilities and expansion of old ones should be provided as well as Federal scholarships and fellowships for students.

Medical Research—The task force fully endorsed the sweeping recommendations of the Jones Committee for a $2 billion national research effort by 1970.

Medical Care Facilities — Increased Federal grants should be authorized for construction of long-term care facilities such as nursing homes. Also long-term, low-interest Federal loans should be available for construction of non-profit hospitals, nursing homes and group practice clinics.

New Health Institutions—A National Academy of Health, comparable to the National Academy of Sciences should be created to honor significant achievements in the field and insure a continuing body of advisers for the Government.

A National Institute of Child Health should be created at the National Institutes of Health to emphasize the Government's concern with youth as well as the aged. ■

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TEST-TUBE ANTIBODIES: NOT SO WILD A DREAM

Researchers move a step closer to commercial in vitro production of immunizing agents

Since the days of Alexis Carrel, immunologists have quarreled over whether cells *in vitro* do or do not produce antibodies. Eminent investigators have infected tissue cultures with certain pathogenic organisms and produced antibodies. Equally eminent investigators, using other organisms, have produced none—even though the organisms were known to yield antibodies *in vivo*.

A five-year study by a Merck Institute team may have uncovered a cause of these conflicting results. Reporting to a symposium of the New York Academy of Sciences, immunologist John M. McKenna, now at the University of Pennsylvania, described experiments in which rabbits were injected with bovine gamma globulin (BGG) and then sacrificed. Bits of the animals' spleens, placed in a culture medium and treated with more BGG, often produced moderate yields of antibody for several days.

Following up a suggestion from German investigators, the Merck group then dosed a second group of rabbits with endotoxin from Salmonella bacteria 24 hours before the animals were sacrificed. Spleen cultures from these animals showed an antibody yield eight times that of the first group. Under some conditions, the endotoxin pre-treatment made the difference between some antibody production and none at all.

This potentiating effect, Dr. McKenna believes, may explain the contradictory findings in earlier studies. He notes that all microorganisms that have been shown to produce antibodies *in vitro* contain endotoxins, while unproductive organisms do not. Further study of the endotoxin reaction, he suggests, may bring nearer the long-sought goal of commercial antibody production *in vitro*.

DR. McKENNA activates cell cultures.

The Merck group next attacked the problem of secondary immunity by comparing antibody yields by spleen fragments and by cultures of monocyte cells alone. Spleen tissue from animals that had received a booster shot of BGG a month or two after their first injection produced the copious antibody yields characteristic of secondary immunity. On the other hand, tissue from animals that had received one injection or none showed only low-level primary immunity. Monocyte cultures displayed only primary immunity regardless of which animals they came from.

Evidently, Dr. McKenna concludes, primary immunity depends on the monocytes alone. Spleen tissue, however, contains both monocytes and lymphocytes. And it is the latter which produce secondary immunity—if the animal had a booster.

This requirement would indicate that the lymphocytes cannot produce secondary immunity on their own but must be primed by the monocytes' initial reaction. This priming process may involve "some chemical modification of the antigen by the more primitive monocyte system."

However, Dr. McKenna notes, lymphocytes rapidly lose their activity *in vitro,* unlike the much hardier monocytes. Thus, they will not survive long enough to yield antibodies unless they are already "set" for production when moved to the culture medium. ■

BLEEDING HALTED BY NEW SURGICAL DRESSING

For the hemophiliac and the physician who treats him the need for surgery—even tooth extraction—is a frightening prospect.

A new surgical dressing that effectively stops bleeding and then innocuously melts away into the body is proving an effective hemostatic agent in such a situation.

Moreover, the new dressing stifles bleeding in accident and surgery cases, has helped save lives in heart surgery and halted blood seepage in wounds of the vascular viscera, notably the kidney, liver and spleen. It has also been used successfully in brain operations and in skin grafting.

This is the summation of experience with *Surgicel* (Johnson & Johnson), an oxidized regenerated cellulose product, as reported by a panel of clinical investigators. But the panel cautions that the dressing should be used discreetly, that it is not a substitute for good surgical technique.

Surgicel can be used wherever sutures or cautery are not practical, reports Dr. Joseph M. Miller, Johns Hopkins surgeon and chief of surgical services, Veterans Administration Hospital, Ft. Howard, Md.

Dr. Miller reported on 200 cases involving a wide variety of surgical procedures, and on 40 skin cases where *Surgicel* was used to halt capillary bleeding over large areas without impeding healing.

Hemophiliacs as a rule require an average of ten transfusions after the extraction of a single tooth, according to Dr. Aaron Finkelman (DDS), head of the oral surgery department, Jefferson Medical College Hospital, Philadelphia.

But using *Surgicel* as a packing or plug in the tooth socket, Dr. Finkelman and his staff have been able to reduce the required transfusions to practically none. And hospital stays, which once averaged three weeks after tooth extractions, have been cut to 1½ days.

Surgicel is an oxidized regenerated cellulose of a slightly acid nature. Over a long period of time, it degenerates and dissolves in the alkalinity of the blood. The initial hemostatic action is based on its affinity for hemoglobin, with which it forms a sort of gelatinous clot. Since it does not rely on normal clotting mechanisms, it is useful in hemophilia and other blood dyscrasias. ■

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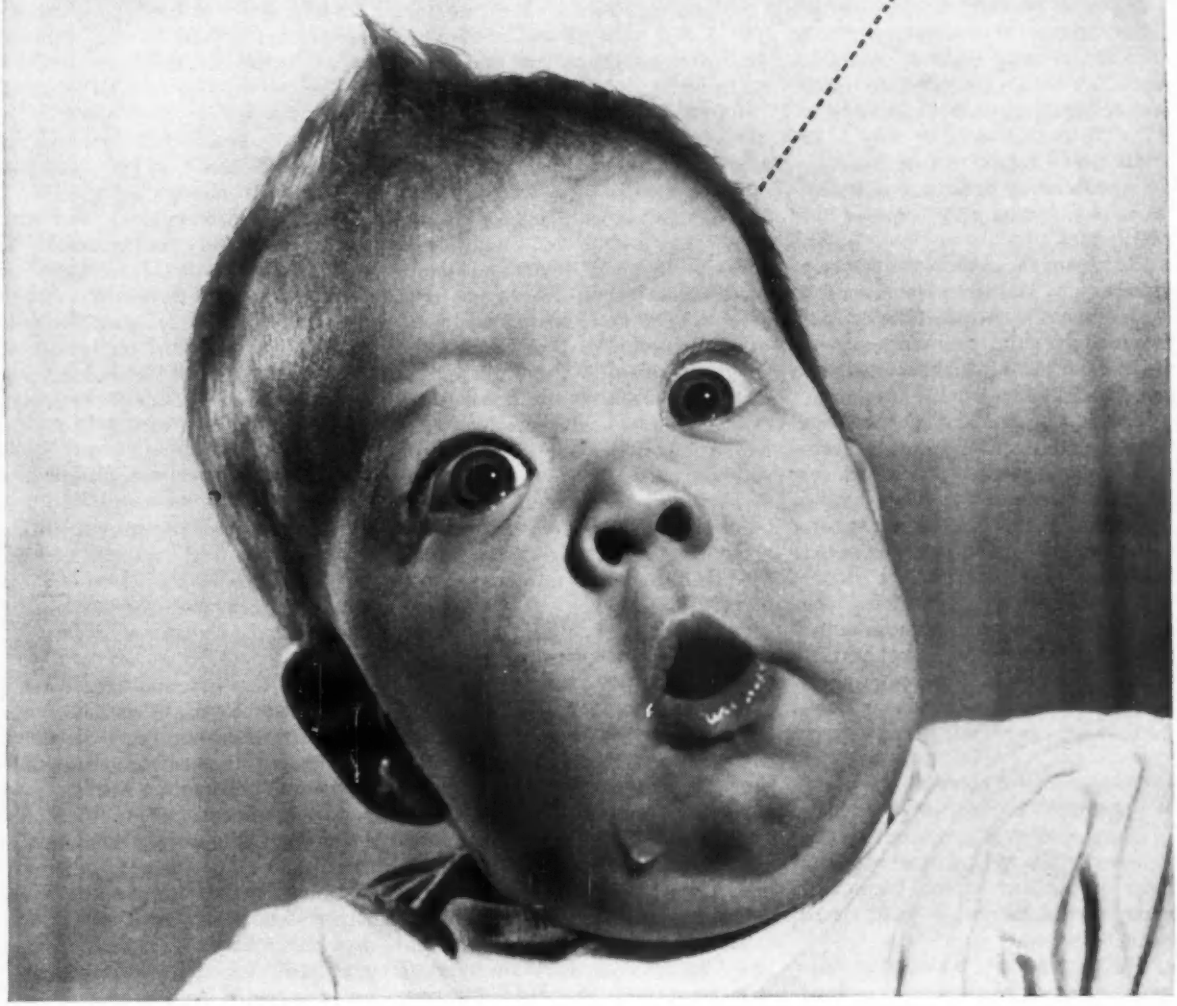

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1. Kaessler, H. W.: Arch. Ped. 74:47 (Feb.) 1957. 2. Kahan, H. et al.: Arch. Ped. 73:125 (Apr.) 1956.
3. Editorial: J.A.M.A. 165:254 (Sept. 21) 1957.

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Editor's Choice

HORMONES SUBSTITUTE IN ANTERIOR PITUITARY FAILURE

Anterior pituitary failure may be either primary or secondary, but it is rarely primary and the causes of secondary failure are manifold. Finding the right one sometimes requires a search from A to X. It may be an aneurysm or xanthomatosis, meningitis or sarcoidosis, leukemia or thrombosis, to mention only some of the possibilities.

Removing the cause is the first step in treatment. The second involves giving hormones to correct endocrine deficiencies resulting from progressive failure of the target glands—the gonads, thyroid and adrenals.

Correcting adrenal deficiency with cortisone or its equivalent takes precedent. USP thyroid provides replacement for the non-functioning thyroid gland, and gonadal deficiency is corrected by androgens for men and estrogens for women.

Fortunately, these hormones enable today's patients with anterior pituitary failure to lead almost normal lives if replacement therapy is adequate. *Randall and Rynearson; Postgrad. Med., Jan. 1961, pp. 24-30.*

AMPUTATION LIMITS SPREAD OF LYMPHANGIOSARCOMA

Occasionally, a postmastectomy patient may develop chronic lymphedema of the arm which eventually leads to virulent, usually fatal, lymphangiosarcoma.

The first reported case of ten-year survival after amputation of the affected limb points to the merit of such a radical procedure. Amputation, though admittedly deforming and disabling, apparently does limit the spread of the malignancy. In the case cited, interscapulothoracic amputation was employed and six months after amputation local excision was utilized successfully for a recurrence in the scar tissue. *Dembrow and Adair; Cancer, Jan.-Feb. 1961, pp. 49-50.*

NATIONAL HEALTH SERVICE IS A QUAGMIRE TO MANY MDs

For British MDs, with National Health Service on one side and the patient on the other, "the path between the quag and the ditch is narrow indeed," to use Bunyan's words.

The downfall of many a British MD is "non-compliance with directives and regulations." For example: The doctor must fill out as many as 16 certificates per patient; and he has no less than 50 forms of various kinds to use for different purposes. There are also forms to be filled when he refers patients, and penalties for not referring them.

What sort of call, he must ask, demands an "instant visit"? How is he to know if a sick infant with loose bowels may be on his way to fatal enteritis? Failure to comply could end in an accusation of "not fulfilling the terms of service." From there, the doctor's route leads through a series of investigating councils and committees, tribunals and appeals, with or without counsel.

Furthermore, he is kibitzed by a bureaucracy that often knows less about his business than he. *Carling; Medico-Legal Jour., Part Two, 1960, pp. 67-68.*

ROUTINE EXCISION OF NEVI MAY NOT BE JUSTIFIED

To excise or not to excise is the key question with regard to plantar or palmar nevi. While the "ayes" have generally carried the vote, there still are some dissenters.

In a U. S. Navy medical survey of 1,100 men and women, the overall incidence of nevi in the plantar and palmar regions was 17.5 per cent for males and 28.7 per cent for females. Based on this data, the estimated rate of melanomatous changes appears to be less than 0.02 per cent—making it evident that "there are no substantial reasons" for adopting a program of routine excision as treatment for either plantar or palmar nevi. *Wilson and Anderson; Cancer, Jan.-Feb. 1961, pp. 51-52.*

AS THE NOSE GOES, SO GOES THE PERSONALITY

In the aftermath of an "epidemic" of nose repairs, some patients have longed to return to their former appearances by having their faces restored. These owners of new noses feel guilty—as if they had betrayed their families' heredity.

Inwardly and unwittingly, some even regard the new well-polished nose as a foreign object—though outwardly they admit to an improvement. Behind the lure of plastic surgery, behind the need for ready-made and "canned" beauty there often hovers a deep-seated cultural neurosis. Obsessed by the fear of not being accepted by the herd, many people seek uniformity of clothes and face—thereby becoming "faceless" themselves.

Such faceless persons who have undergone surgery finally come to the psychiatrist because they feel they have lost the essence of their own personality. They want to get back their old identity in a last rebellion against the conforming influences of a society that venerates eternal youth. *Merloo; Am. Pract., Jan. 1961, pp. 51A-52A.*

BLOOD FROM UNIVERSAL DONOR CAUSES SERIOUS REACTION

Transfusion reactions resulting from formation of antibodies to the hr″(e) factor in the blood are extremely rare because all but about 2.4 per cent of the population have hr″(e) factor.

In the case described, the patient, who was one of the minority, was found to have anti-hr″(e) in her blood. Presumably, she had been sensitized by her four pregnancies, since her husband was homozygous for hr″(e) and all of his children would, therefore, carry the hr″(e) antigen. When the first pregnancy was terminated by cesarean section, additional sensitization may have resulted from transfusion of a pint of blood that was probably hr″(e)-positive. During cesarean section for the fourth pregnancy, the patient was given another transfusion. She immediately developed a classical hemolytic reaction and acute renal failure from which she later recovered.

Giving blood from a universal donor in this case proved to be extremely dangerous. This practice should be condemned, both as a routine procedure and for emergency use. A sensitive cross-match technique using enzyme-treated cells, and routine screening tests for detection of antibodies, especially for patients who have had previous pregnancies or multiple transfusions, would prevent such serious hemolytic reactions. *Wei-Ping Loh; Am. Jour. Clin. Path., Feb. 1961, pp. 111-15.*

Product News

FOR URINARY INFECTIONS

Septamide (Lemmon), a triple combination of drugs for the treatment of urinary tract infections, contains methenamine mandelate and sulfacetamide to combat urinary tract pathogens and homatropine methylbromide to help relieve pain. It is indicated in urinary tract infections associated with pain or discomfort and as prophylaxis before and after urologic surgery, catheterization and cystoscopy.

The usual precautions for sulfonamide therapy should be observed. If gastric distress occurs, the drug should be discontinued. It is contraindicated in acute renal failure.

Adult dosage of *Septamide* is one to two tablets three or four times daily. Therapy should be continued until several days after apparent clearing of infection.

Each *Septamide* tablet contains 250 mg methenamine mandelate, 250 mg sulfacetamide and 2.5 mg homatropine methylbromide. Supplied in bottles of 100.

FOR COUGHS

Calcidrine Syrup (Abbott), an apricot-flavored preparation for coughs due to colds, contains calcium iodide, which promotes rapid clearance of airways by its mucous liquifying action, as well as codeine, pentobarbital and ephedrine.

Dosage in adults is one or two teaspoonfuls every two to four hours; in children six to ten years old, one teaspoonful. Warning: Children under six should be given *Calcidrine* only under supervision of a physician. It should not be taken by persons allergic to iodides, or by persons with thyroid disease, except under the direction of a physician. Available in 4 oz and pint bottles.

FOR DIARRHEA

Entoquel (White), a specific, nonnarcotic antiperistaltic agent (thihexinol), comes in two syrup forms, one containing thihexinol methylbromide alone for nonspecific diarrhea and one containing thihexinol plus neomycin for bacterial diarrhea.

Thihexinol acts almost exclusively to inhibit gastrointestinal motor function and does not interfere with gastric secretion, digestive processes, or produce undesirable atropine-like effects when administered in recommended dosage. However, it is contraindicated in patients with glaucoma.

Usual dosage of *Entoquel* in children under six is ½ to 1 teaspoonful four times daily; children from six to 12 years, 1 to 2 teaspoonfuls four times daily; and children over 12, 1 tablespoonful four times daily. Dosage of *Entoquel* with neomycin is the same for children under six; for children over six, 1 to 2 teaspoonfuls four times daily; and for adults, 1 tablespoonful four times daily.

Each teaspoonful of *Entoquel* contains 5 mg thihexinol. *Entoquel* with neomycin contains 50 mg neomycin per teaspoonful. Available in 6 oz bottles.

FOR CONTACT LENS WEARERS

With the *Lensertor*, applying contact lenses becomes a one-hand operation. This seven-inch-long instrument puts lenses in place neatly and precisely, eliminating slips and smudges. The little suction arm (right, top of picture) picks up the lens and deposits it right on the pupil while the two rubber prongs gently hold the lids apart and keep them from flickering. Made by the Nylacore Corp., Glen Cove (L.I.), N. Y.

IN GASTRIC DISEASE

Nacton (McNeil), an anticholinergic, reduces hydrochloric acid formation without interfering with the protective alkaline nonparietal secretions of the gastric mucosa. In addition, it has an antispasmodic effect in gastrointestinal syndromes involving hypermotility. Thus, it is indicated in peptic ulcer, hyperchlorhydria, pancreatitis, enteritis, gastritis, dumping syndrome, ulcerative colitis and duodenitis.

The average effective dosage of *Nacton* is 4 mg three or four times daily, before meals and at bedtime, but dosage should be adjusted to individual requirements.

In recommended dosage, the only side effect reported has been slight dryness of the mouth. However, if dosage is increased beyond usual therapeutic levels, or if therapy is interrupted and begun again at the same dosage level, side effects characteristic of anticholinergic drugs can occur. Caution is advised in giving *Nacton* to patients with glaucoma, prostatic hypertrophy, pyloric obstruction, coronary artery disease or tachycardia.

Nacton is supplied in 4 mg scored tablets in bottles of 100 and 500.

IN CIRCULATORY DISORDERS

Roniacol Timespan (Roche) is a new dosage form of *Roniacol* (beta-pyridyl carbinol), a vasodilator useful in the treatment of circulatory disorders, including generalized arteriosclerosis, night cramps, chilblains, intermittent claudication, diabetic endarteritis and vertigo due to impaired circulation.

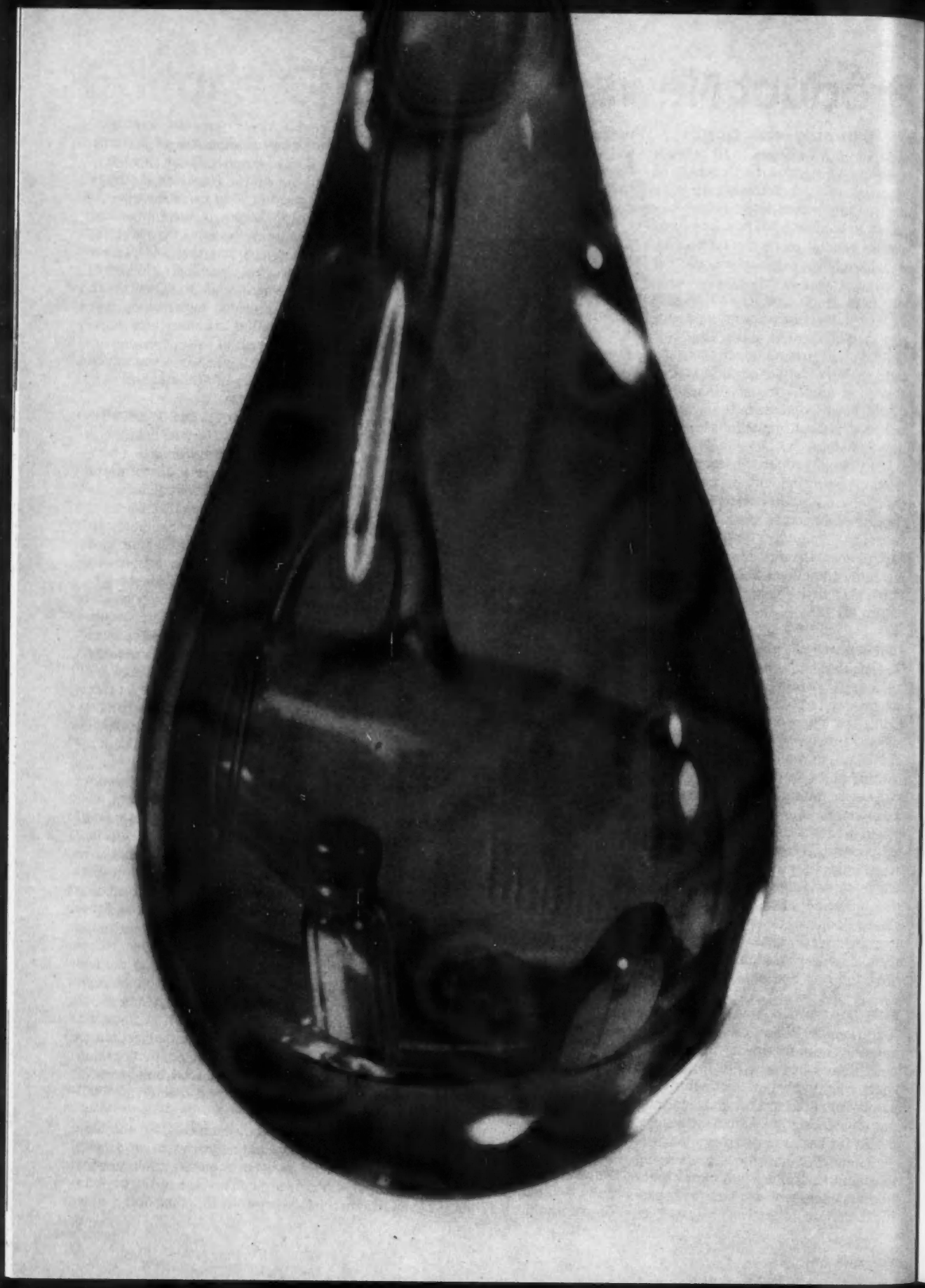
Roniacol Timespan tablets contain 150 mg *Roniacol* tartrate in a slow-release form which helps to relieve symptoms in these conditions for a period of approximately 12 hours. Because of this prolonged action, one tablet twice daily is usually sufficient to maintain optimal therapeutic response. Available as capsule-shaped sustained release tablets in bottles of 50.

BOOKLETS AND FILMS

A Guide Book Describing Pamphlets, Posters, Films on Health and Disease is an annotated reference to free and inexpensive health information materials. It includes information on about 1440 printed items and several hundred films and filmstrips on topics ranging from "Accidents" to "X-rays." Items are listed in dictionary form with a description of each.

Material listed in the *Guide Book* was selected because of technical accuracy, treatment of the subject matter consistent with current expert opinion, absence of commercial bias, cost—if any—less than one dollar and availability.

It can be obtained from the State of Maryland Department of Health, 301 West Preston St., Baltimore 1, Md., for $1. The cost of the book includes periodic supplements.



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"...extraordinarily effective diuretic..."[1]

Efficacy and expanding clinical use are making Naturetin the diuretic of choice in edema and hypertension. It maintains a favorable urinary sodium-potassium excretion ratio, retains a balanced electrolyte pattern, and causes a relatively small increase in the urinary pH.[2] More potent than other diuretics, Naturetin usually provides 18-hour diuretic action with just a single 5 mg. tablet per day — economical, once-a-day dosage for the patient. Naturetin c̄ K — for added protection in those special conditions predisposing to hypokalemia and for patients on long-term therapy.

Supplied: Naturetin Tablets, 5 mg., scored, and 2.5 mg. Naturetin c̄ K (5 c̄ 500) Tablets, capsule-shaped, containing 5 mg. benzydroflumethiazide and 500 mg. potassium chloride. Naturetin c̄ K (2.5 c̄ 500) Tablets, capsule-shaped, containing 2.5 mg. benzydroflumethiazide and 500 mg. potassium chloride. For complete information consult package circular or write Professional Service Dept., Squibb, 745 Fifth Avenue, New York 22, N. Y.

References: 1. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Therapy 5:60 (Feb.) 1960. 2. Ford, R. V.: Current Therap. Res. 2:92 (Mar.) 1960.

Naturetin
Squibb Benzydroflumethiazide

Naturetin c̄ K
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SQUIBB

Scissors & Scalpel

DRINKERS' LAMENT

"Breast feeding continues to get lip service from everyone except the baby," says Dr. Herman F. Meyer of Chicago.

Despite current efforts to encourage breast feeding, Dr. Meyer told a recent nutrition meeting that only 21 per cent of the more than 2½ million infants born in hospitals in 1956 were nursed. Ten years previously, 38 per cent of all infants were breast fed.

Advises pediatrician Meyer: "Breast feeding gives the neonate a sense of security which echoes down his childhood. It also contributes to the mother a sense of being necessary."

DIGITAL SOCK

Foot health would be considerably improved if stockings were made to fit the toes as gloves are made to fit the fingers.—DR. FRED BROUN, Chicago podiatrist.

A digital sock is the thing to wear,
A digital sock is without compare.
It keeps the foot healthy, clean and neat,
Dressed in it, the feet's complete.
Such a sock, podiatrists state,
Does not bunch or aggravate,
Helps to keep the digits straight,
In every way should captivate
Those whose feet intimidate.
And so about our tasks we go,
Our toes aligned, our feet just so,
Convinced that careful digitation
Will ease all pedal irritation.

BELLY BANK

One man with an iron constitution is a Brooklyn mental patient who swallowed no less than 258 metal objects, including 26 keys, 39 files, 16 religious medals, a beer can opener, a knife blade, nail clippers and enough coin of the realm to total $19.19.

The articles were recovered during an operation last spring after x-rays and a barium tracing. The surgeons—Drs. Alan A. Kane, Benjamin Ginn and Bernardo A. Mora, Jr.—found that their patient's stomach had developed an unusual pouch—"something like a kangaroo's"—which held the articles. In various stages of decomposition, the articles weighed more than three pounds.

The patient is apparently still engaged in swallowing foreign objects, however. Dr. Kane took an x-ray the other day and found "something that looks like the plastic tubing from an intravenous set. We won't operate," he added, "unless he gets sick from it. He may yet pass it."

DIAGNOSIS BY DECOR

"If ever I am called to see a pretty woman in an ultra-feminine bedroom, I am immediately on my guard," said the doctor. "All those frills indicate arrested development, so I don't believe a word she says."

With this introduction, an article in the British humor magazine *Punch* proceeds to give some house-call diagnostic hints based on a glance at the bedroom decor.

"A fondness for pink is infantile, too," the bedroom diagnostician goes on, "and I assess a patient's immaturity in proportion to the amount of the color used. The more pink, the more childish she will be.

"Today, I often come up against furnishings that seem exciting and daringly different, and these patients have plenty to say about everything. They like to be told about their illnesses without reservation; no fuddy-duddy phrases or comforting idioms for them.

"Twin beds always make me sigh. Young couples who sleep alone may find themselves suffering from much more than cold feet. The solitary sleeper grows cold of heart, mistrustful and afraid of life, and I always tell twin-bedders to try sleeping together for a few weeks before sending for me again. Most of their ailments are trivial anyway and could be cured by normal nighttime companionship."

SOUND OFF

A large symphony or jazz band may enchant the listener but drive the players deaf.

So, at least, two otolaryngologists at the New York Eye and Ear Infirmary warn, in appealing for brass and percussion players to come forward for hearing tests. The subjects are needed to check whether hearing losses could occur from constant exposure to certain intensities of sound, however harmonious.

"There are several groups of professional musicians who are actually exposed to high intensities of musically used sounds which are potentially dangerous," write Drs. Godfrey E. Arnold and Francis Miskolczy-Fodor in the *Archives of Otolaryngology*.

The results of the proposed tests, they say, will be released when sufficient information has been collected to permit "sound conclusions."

LABOR NEWS

The New Jersey Senate appears to be a body with a logical mind. Not long ago it referred a bill on county maternity hospitals to its labor committee.

NAME DROPPER

Brevity is the soul of wit, as the Bard pointed out, and in so far as trade names of drugs are concerned, they are easier to write, to say and to remember than the generic names, maintains Dr. R.B.O. Richards of Uxbridge, England.

"Who is going to prescribe 'thioproperazine methanesulphonate' if 'mejaptil' is available?" he asks in a letter to the *British Medical Journal*. "I suggest that if a little thought is used no single drug need have more than three syllables in its name. These long names are mostly a vain attempt to suggest chemical structure, which should be abandoned when it cannot be done briefly."

Lending point to Dr. Richards' contention, the editors (perhaps unwittingly) placed his letter under an austere note requesting correspondents to keep their letters short.

PLACEBOS

"To argue that research must be curtailed until all other resources have caught up is like arguing that the brilliant child should not be educated until all the stupid ones have caught up."—DR. LOWELL T. COGGESHALL.

"The patient said his greatest wish was for Gus Triandos to hit a home run. He showed gross disorganization in his thinking."–Psychiatrists' report.

"Cancer research keeps more people alive than are killed by the disease."
—DR. ALBERT SZENT-GYORGYI.

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DOCTOR'S BUSINESS

The Treasury Department is taking steps to give each taxpayer an account number to permit machine processing of all accounts. Meantime, the Department says its drive to get people to report voluntarily on their dividend and interest income is achieving "a considerable degree of success."

Higher gasoline taxes in several states may be one result of the continuing popularity of compact cars. Oil industry sources are estimating motor fuel consumption will fall seven per cent short of the level that might have been attained with only standard-sized vehicles on the roads. As a consequence, at least six states (Idaho, Mo., Okla., Pa., Texas and W. Va.) are planning to boost their gasoline taxes.

A Federal district court has held that a wife's travel expenses are deductible if she accompanies her husband on a physician's recommendation. The court made the ruling in the case of a diabetic textile executive whose wife went with him on his frequent business trips here and abroad. It held her presence was for a legitimate business purpose and was not intended as a vacation, as the Government argued.

The American College of Radiology has warned that a California MD is soliciting members for a so-called radiological organization "without a constitution, by-laws or officers." First called "The American Society of Diagnostic Radiology," the group later changed its name to "The American Society of Clinical Radiology." Says the ACR: "The use of the term 'radiology' may cause some physicians to identify the group as composed of those who have been examined and certified to be competent in radiology."

A new type of annuity insurance plan tailored primarily for professional men is now on the market. It's the variable annuity policy which provides for increasing annuity payments year after year to compensate for inflationary pressures. The plan is like a mutual fund since a high proportion of the premiums are invested by the company in carefully selected common stocks which usually go up in value during extended periods of inflation. With increase in equity, the company is then able to raise annuity payments to policy holders. Prudential, Equity Annuity Life Insurance Company and Variable Annuity Life Insurance Company are beginning to write policies.

For the doctor who has to make house calls over treacherous roads the American Automobile Association recommends reinforced tire chains equipped with teeth or cleats. On icy roads they are twice as good for starting and driving as ordinary chains and far better than snow tires. But snow tires do give about 50 per cent better traction than ordinary tires in loose snow.

To help young doctors over their initial financial hump, the Continental Illinois National Bank of Chicago is offering a new plan. The bank will lend a doctor starting practice a lump sum for equipment costs and office rental, plus a checking account balance for operating expenses. Repayment on an installment basis will be deferred for six months until the doctor has had a chance to begin building up his practice.

The doctor who plans to contribute stock which has increased in value to his alma mater while retaining income rights had better be careful. He risks getting hit with a capital gains tax on the gift even though he won't personally benefit from the stock growth. This can happen if the college sells the stock and invests the proceeds in tax-free municipal bonds from which the donor receives the interest. Best bet to avoid trouble: stipulate that the college hold on to the stock or, if sold, have the school invest the proceeds in taxable stocks or bonds.

Reports that the Internal Revenue Service is mounting a broad enforcement campaign against physicians are emphatically denied by high-level Washington officials. Their comment: If the IRS were to single out any one group for special investigation, the ensuing protests around the country would cancel out any presumed advantage. They do concede, however, that auditing returns is at a peak as a result of stepped-up enforcement measures. But they insist the added pressure is on everybody—not just doctors.

Lifts depression...as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety...rapidly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient – *they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation – *they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety – both at the same time.

Acts swiftly – the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly – often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely – no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function – frequently reported with other antidepressant drugs.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. **Supplied:** Bottles of 50 light-pink, scored tablets. Write for literature and samples.

▲Deprol▲®

WALLACE LABORATORIES / *Cranbury, N. J.*

CD-2125

Names in the News

POSTS AND AWARDS

Dr. George W. Beadle, (photo) Nobel Prize-winning geneticist, acting dean of the faculty and chairman of the division of biology at California Institute of Technology, chosen as chancellor of the University of Chicago. Dr. Beadle, with **Dr. E. L. Tatum** of the Rockefeller Institute, received the 1958 Nobel Prize for medicine for the discovery that genes act by regulating specific chemical processes.

Dr. Jesse D. Rising, associate professor of medicine and pharmacology, the University of Kansas School of Medicine and Medical Center, appointed chairman of the department of postgraduate medical education. **Russell H. Miller,** associate director of the Medical Center, named president-elect of the Kansas Hospital Association.

Dr. Allan E. Kark, chairman of the surgery department of the University of Natal in Durban, South Africa, named director of the surgery department of Mount Sinai Hospital, N. Y. C.

Dr. Richard L. Meiling selected as dean of the College of Medicine at Ohio State University succeeding dean emeritus **Dr. Charles A. Doan.**

Dr. K. J. Ryan of Harvard University Medical School, appointed professor and head of the department of obstetrics and gynecology at Western Reserve University.

Dr. Detlev W. Bronk, president of the Rockefeller Institute, elected an honorary member of the Brazilian Academy of Science, and an honorary doctor at the University of Brazil.

Dr. Takeo Hara of Fukuoka, Japan, awarded a Reader's Digest International Fellowship in Rehabilitation at the Institute of Physical Medicine and Rehabilitation, New York University Medical School. The appointment was made in Tokyo by Ambassador Douglas MacArthur II, and in New York by **Dr. Howard A. Rusk,** president of the World Rehabilitation Fund.

Dr. Martin C. Sampson, former associate in endocrinology at the University of Pennsylvania's Graduate School of Medicine and senior member of the clinical research staff of Smith Kline & French Laboratories, appointed director of medical relations of the Schering Corporation.

Dr. Floyd W. Denny Jr., of Western Reserve University School of Medicine, named head of the department of pediatrics of the University of North Carolina School of Medicine, succeeding **Dr. E. C. Curnen Jr.,** who has accepted a similar position with Columbia University's College of Physicians and Surgeons.

Dr. Clark K. Sleeth, specialist in gastrointestinal physiology and member of the medical faculty of West Virginia University, appointed dean of the institution's School of Medicine succeeding **Dr. E. J. VanLiere.**

Dr. Frank Glenn, professor and chairman of the department of surgery, Cornell University Medical School, N. Y. C., elected 50th president of the New York Academy of Medicine.

Dr. Seymour S. Kety, chief of the laboratory of clinical science of the National Institute of Mental Health, appointed professor of psychiatry and director of the department of psychiatry, Johns Hopkins University School of Medicine. A research scientist, Dr. Kety has made exhaustive studies on the biology of schizophrenia and is the editor-in-chief of the *Journal of Psychiatric Research.*

Dr. Douglass S. Thompson, assistant professor of medicine and director of health services at New York University, named director of student health at the University of Pittsburgh.

Dr. S. Gorham Babson, Portland, Ore., pediatrician, made associate professor of pediatrics at the University of Oregon Medical School.

OBITUARIES

Dr. Cyril H. Haas, 86, medical missionary in Turkey, he treated more than 20,000 patients annually in his clinic and became known as a worker of "miracles" among the poor; after his service in the Near East he became a volunteer staff physician at Upland Hospital, Pleasant Hill, N. C.; Jan. 8, in Pleasant Hill.

Dr. James M. Eaton, 55, director of the department of surgery and professor of orthopedic surgery of the Philadelphia College of Osteopathy; Jan. 1, in Philadelphia.

Dr. Thomas Dooley, 34, medical missionary, author and driving force behind Medico; his village hospitals and care of Communist refugees in Laos brought him fame and acclaim; as the result of a fall in 1959 he developed sarcoma, but continued his work almost to his death; of cancer; Jan. 18, in New York City.

Dr. John Brown Jr., 80, physical fitness proponent, former director of the National Physical Education Committee of the Young Men's Christian Association and a member of the U.S. Olympic Committee from 1924 to 1936; Jan. 9, in Miami.

Dr. James Flippin, 97, North Carolina's oldest physician and in active practice until a few months before his death; Jan. 11, in Pilot Mountain, N. C.

Dr. Lester R. Whitaker, 69, Portsmouth, N. H., surgeon and prominent civic leader; Jan. 9, in Boston.

Dr. Chevalier L. Jackson, 60, founder, with his late father, of Temple University Hospital's bronchoscopic clinic where thousands of patients were treated for removal of foreign objects from the throat and lungs; professor and chairman of the department of laryngology and bronchoesophagology at the Temple School of Medicine, he was the author of several textbooks on the subject; he helped establish the Philadelphia Grand Opera Company and was past president of World Affairs Council; of a heart attack; Jan. 13, in Schwenksville, Pa.

Letters to t

INFORMATION, PLEASE

You mention the big growth seen for geriatric specialists (MWN, Dec. 16, *Doctor's Business*), and that some doctors are already finding that professional ventures in so-called retirement homes are very successful.

We have such a large proportion of old people in our area that I sometimes think that all of us practitioners have quite a grasp of geriatric problems.

Two years ago we took our family for a trip through the Southwest. We were enchanted about the country. Thought at the time what a wonderful place to spend one's declining years. My wife is an ex-hospital dietitian, and together we might be able to run a bang-up good retirement colony somewhere in the Southwest.

Would you please let me know about physicians who have been successful in the retirement-home field?

FREDERICK D. McIVER, M.D.
Plymouth, N. H.

[*Physicians who have had experience in retirement colonies might like to write Dr. McIver.*—ED.]

NO-LOAD FUNDS

In *Doctors Business* (MWN, Dec. 16) you point out that there are mutual funds available which can be purchased without a sales charge. I gather that these are bought by direct application to the funds. Could you give me the names of several such funds?"

WILSON STARR, M.D.
Columbia-Presbyterian Medical Center, New York, N. Y.

[*Among leading "no-load" funds are: Energy Fund, New York City; T. Rowe Price Growth Stock Fund, Baltimore, Md.; Stein, Roe & Farnham Stock Fund, Chicago, Ill.*—ED.]

PLETHORA OF PAPERS

I congratulate you on your editorial (MWN, Dec. 2). This problem of publications flooding the medical profession has reached annoying proportions and is causing many physicians to spend some of their precious time trying to decide whether to save this material or discard it. This situation, in reality, creates an attitude in the physician which causes him at many

to the Editor

times to discard information which might be of value.

A second problem, not touched upon by your editorial, involves the massive—frequently unjustified—unread and many times unwanted, drug company literature. It is impossible for any one person to ever read or cope with this information.

Even though this massive invasion of literature into private doctor's offices is ethical, it does not make it entirely right.

R. B. RANGLE, M.D.
Baltimore, Md.

TITLE MIXUP

You very kindly published a summary of one of the papers which I presented before the Congress of Neurological Surgeons in Chicago (MWN, Dec. 16, "A Surgeon's Hardest Lesson"). I very much appreciate the attention which you have given this presentation and the kind things you have said about me.

However, I wish to call your attention to two major errors in your article. I am professor of surgery at Northwestern University Medical School and chief of the section on neurological surgery at the Chicago Wesley Memorial Hospital—I am not "head of neurosurgery" or "chief of surgery" at Northwestern University. I am sure that these errors were unintentional and accidental, but I wish to avoid any misunderstanding.

PAUL C. BUCY, M.D.
Chicago, Ill.

WRONG Rx FOR BLUE CROSS

I was most interested to read the "Plan of Action for Blue Cross" MWN, Nov. 4). Dr. MacLean has made some points in this article, but one of his suggested remedies seems entirely wrong to me.

If Blue Cross were to expand coverage to include radiology and pathology service for out-patients, a hospital radiologist would be given tremendous economic and, it seems to me, very unfair advantage over his counterpart in office practice. The latter group is sorely pressed now to compete with the hospitals for out-patients in view of the preferential treatment accorded hospital diagnostic services by the commercial insurance companies.

CHESTER A. STAYTON, M.D.
Indianapolis, Ind.

Dr. Basil MacLean prescribes a plan of action for Blue Cross. He insists that everybody in the community has a right to all the services the hospital could provide. Yet, he fails to include the surgeon, internist and general practitioner in his program.

He would cover anesthesiology, radiology and pathology — a mere drop in the bucket of medical and surgical expenses . . . .

And the AMA recommended in 1933, and has recommended ever since, that Blue Cross cover hospital services and that physicians cover medical services. To do otherwise would put a hospital manager, frequently a lay person, in virtual charge of selecting the quality and quantity of medical service.

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ANTIVIVISECTIONISTS

I have read the editorial by Dr. Morris Fishbein (MWN, Oct. 21, "Antivivisectionists Ride Again!") Although I think this warning is timely, I feel that Dr. Fishbein gave too much attention to the antivivisectionist aspect of the proposed legislation (Senate bill 3570) and glossed over the more far-reaching aspects of the proposal.

After carefully reviewing this proposed legislation, and after reading our Sen. J. S. Cooper's remarks from the *Congressional Record*, it becomes obvious to me that we are dealing with something more than humane treatment of vertebrate animals.

I would suggest that you read carefully the many facets of this proposed legislation and make up your own mind. I hope that the leaders of medicine will awaken to this threat.

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'THIO-TEPA' DOSAGE

In your article "Breast Cancer Recurrences Cut" (MWN, Nov. 4) you state that the dose of *THIO-TEPA* is given intravenously .2 mg/kg at the time of the operation and .2 mg/kg on the second and third post-operative days. This, to me, is confusing.

To my knowledge the first 24 hour period after the operation, or the next day after the operation, is considered the first post-operative day. Forty-eight hours after the operation is considered the second post-operative day.

J. H. MEYER, M.D.
Dayton, Ohio

[*Dr. Meyer is right. The patient receives .2 mg/kg of* THIO-TEPA *at the time of operation, a second dose of .2 mg/kg 24 hours later and a third dose of .2 mg/kg 24 hours after the second dose.*—ED.]

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DOWN THE ROAD TO COMPULSION

Morris Fishbein, M.D.

Elsewhere in this issue (p. 31) HEW Secretary Ribicoff declares his support of President Kennedy's program of medical care of the aged through the Social Security system.

At the White House Conference on Care of the Aged, too, the general consensus was that aged care should be included in Social Security.

Finally, President Kennedy's special task force, headed by Wilbur Cohen (PhD), professor of public welfare administration at the University of Michigan, wholeheartedly endorsed the Social Security approach. (Of course, anyone familiar with Dr. Cohen's expressed views on the problems of medical care could have predicted the nature of his recommendation.)

Once more the same old conflicts that began in the early days of the New Deal have risen to the surface. Dr. Cohen, who was just appointed assistant secretary for legislative matters in the Department of Health, Education and Welfare, was then a conspicuous figure in the Social Security Administration and helped write much of its legislation. He was also a prominent figure in Sec. Oscar Ewing's controversial National Health Conference.

Thus, he is no "Johnny come lately" in this matter of medical care for the aged. And neither am I.

As I wrote back in 1932, history shows that the nations of the world, once they embark on medical care programs, inevitably travel down the path that leads to Government control of medicine. This was the case in Germany with its Krankenkasse, initiated by Bismarck in 1887; in England with its National Health Insurance; and in Sweden with its Compulsory Health Insurance.

As a result, the medical profession in this country has long hoped that we could develop a system that would be distinctly American and free from Government interference. With medical leadership, Blue Cross and Blue Shield have expanded to the point where they include an enormous proportion of the population, and they seem likely to satisfy the needs of all but the indigent and the totally improvident.

True adjustments or changes in medical care programs must be made from time to time. (This is no less true of the British system which is often under fire from the medical profession and is the subject of much Parliamentary debate.)

To care for the elderly ill, Congress last year passed the Mills-Kerr Bill. But even before it has been given a few month's trial, critics have called it "inadequate, demeaning and an administrative monstrosity."

The need for medical care of the aged *does* exist but there continue to be serious questions on the extent of this need. For instance, a recent Health Information Foundation survey ("How Many Old People Really Need Help?" MWN, Jan. 6) suggests that the very sick, the "problem" aged, only constitute about 10 to 15 per cent of all those over 65.

The program enacted last year can be improved by such amendments and by others that experience may show to be desirable. But those who believe in *compulsory* health insurance will not be satisfied with this approach. By linking medical care of the aged to Social Security they want to break the back of the voluntary approach. When they succeed with the over-65 aged, their next target will be preschool children under six. Having brought them into the fold, they will spread their gains to include *all* school children and, in time, other selected groups in the population. Compulsion will become the rule.

Morris Fishbein